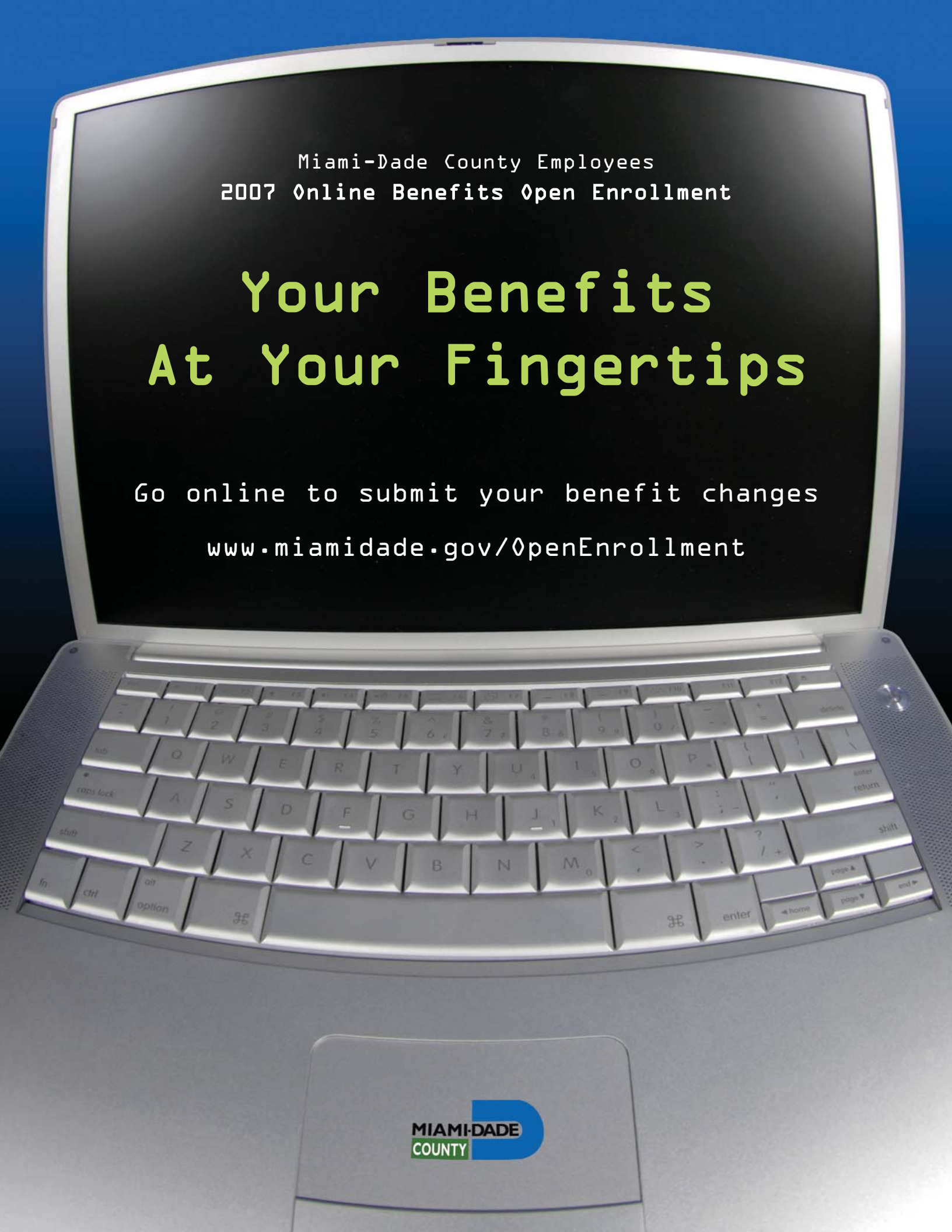

Miami-Dade County Employees
2007 Online Benefits Open Enrollment
Your Benefits
At Your Fingertips
Go online to submit your benefit changes
www.miamidade.gov/OpenEnrollment
MIAMI-DADE
COUNTY

Employee Benefits Resource Directory

Miami-Dade County *Benefits Administration Unit*	305-375-5633 or 305-375-4288 FAX 305-375-1368 or 305-375-1633
Web Site	www.miamidade.gov/benefits
DPR Contact Information	www.miamidade.gov/benefits (*click **DPR listing** from left side)*
On-Site Plan Representatives	Visit or call your on-site plan representative located in the Benefits Administration Unit, Stephen P. Clark Center, 111 NW 1st Street, Suite 2340, Miami, FL 33128

Medical Plans

AvMed	(Mon-Fri, 8:30a-4:30p)	305-375-5306
CIGNA	(Mon-Fri, 8:30a - 5:00p)	305-375-2457
Humana	(Tue &Thu Only, 8:30a - 4:30p)	305-375-4119
VISTA	(Mon & Wed Only, 8:30a - 4:30p)	305-375-5408

457 Deferred Compensation Plans

ICMA-RC	(Tues & Thurs, 9:00a - 4:00p)	305-375-4710
NRS	(Mon & Wed, 9:00a - 4:00p)	305-375-4853

Provider Addresses and Contact Information

MEDICAL

AvMed Health Plan HMO
9400 S. Dadeland Blvd., Suite 420
Miami, FL 33156
(800) 882-8633
TDD: (877) 442-8633
www.avmed.org

CIGNA HealthCare
1580 Sawgrass Corporate Parkway, Suite 200
Sunrise, FL 33323

CIGNA HealthCare
Customer Service, Claims, and
Correspondence to:
P.O. Box 182223
Chattanooga, TN 37422-7223
Open Enrollment Hotline: (800) 962-3136
www.cigna.com

Humana, Inc.
3401 SW 160 Avenue
Miramar, FL 33027
(800) 520-3798
Open Enrollment Hotline: (888) 393-6765
www.Humana.com

Humana Claims Office
P.O. Box 14602
Lexington, Kentucky 40512-4602

JMH Health Plan HMO
1801 N.W. 9 Ave., Suite 700
Miami, FL 33136
(305) 575-3700
(800) 721-2993
www.jmhhp.com

Vista Healthplan, Inc.
1340 Concord Terrace
Sunrise, FL 33323
(866) 847-8235
Open Enrollment Hotline: (888) 679-9148
TDD: (888) 444-7352
www.vistahealthplan.com

DENTAL

American Dental Plan (ADP)
100 Mansell Court East
Roswell, GA 30076
(800) 432-3376
(305) 262-1333
www.compbenefits.com

MetLife Dental
Dental Claims Unit
P.O. Box 981282
El Paso, TX 79998-1282
(800) 845-1870
TDD: (888) 638-4863
www.metlife.com/mybenefits

Oral Health Services
5775 Blue Lagoon Drive, Suite 400
Miami, FL 33126
(800) 432-3376
(305) 262-1333
www.compbenefits.com

VISION

Optix Vision Plan/Vision Care, Inc.
P.O. Box 30349
Tampa, FL 33630-3349
(800) EYE-CURE (393-2873)
www.compbenefits.com

OTHER

ARAG®
P.O. Box 9171
Des Moines, IA 50309
(800) 247-4184
http://members.ARAGgroup.com/MDCounty

ICMA-RC Services, LLC.
Southeast Territory Office
2655 LeJeune Road, Suite 545
Coral Gables, FL 33134
Phone: (305) 569-0728 Fax: (305) 569-0790
Customer Service: (800) 669-7400
www.icmarc.org/xp/plans/miamidade

NACo/Nationwide Retirement Solutions (PEBSCO)
P.O. Box 1541
Boca Raton, FL 33429
(305) 937-1176 (Miami) Fax: (561) 338-9731
FL WATS (800) 432-0822
Account Information (877) 677-3678
www.miamidade457.com

Metlife Disability
Metlife Disability Unit
P.O. Box 14590
Lexington, KY 40511-4590
(888) 463-2023; Fax (800) 230-9531 or (866) 690-1264
www.metlife.com/mybenefits

(overnight deliveries)
Metlife Disability c/o ACS
2025 Lesstown Road, Suite A-2
Lexington, KY 40511

Completed evidence of insurability forms/inquiries
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
(800) 638-6420; FAX (859) 225-7909

Fringe Benefits Management Company (FBMC)
P.O. Box 1878
Tallahassee, FL 32302-1878
(800) 342-8017
Interactive Benefits 1-800-865-3262
www.myFBMC.com

The material contained in this Handbook does not constitute an insurance certificate or policy. This information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusions of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies. Employees receive benefit certificates for those benefits selected.

Miami-Dade County Benefits Handbook

Table of Contents

Important Dates to Remember

Your online Open Enrollment dates are: October 30, 2006, through November 30, 2006.

For employees without computer access, please contact your departmental personnel representative.

Your 2007 Period of Coverage dates are: January 1, 2007, through December 31, 2007.

Web Access to Plan Information

Do you need a provider directory? Find a participating pharmacy, obtain a preferred drug formulary list? View your plan benefit summary or co-payments? Your health plan's Web site is a valuable resource for obtaining benefits information 24 hours a day, seven days a week. In addition to the "basics," here are the highlights of additional benefits available online:

AVMED (800) 882-8633 - www.avmed.org/go/mdpht
Print and request ID cards, view benefits, eligibility, co-pays, authorizations, review prescription drug list, complete a Health Risk Assessment to receive a free Healthwise Handbook, and much more.

CIGNA (800) 962-3136 - www.cigna.com: Request an ID card, change PCP, download claim form, access claims history, access personal authorization information, visit online customer service, obtain answers to frequently asked questions.

HUMANA (800) 520-3798 - www.humana.com: Access customized homepage at MyHumana., check claims history, view prescription co-payment by drug name, order ID cards, report an address change, use risk assessment tools to gain better understanding of your overall health.

JMH (305) 575-3700 - www.jmhhp.com: View a summary table of benefits (by product line), search for a provider in our network (by specialty/zip code), view our member newsletter, get answers to medical questions by using links to external web site, such as: U/M School of Medicine, U/M Behavioral Health, WebMD, Med Impact (pharmacy benefit management system), visit Quest Diagnostic for Lab services and location and send e-mail inquiries to Member Services.

VISTA (866) 847-8235 - www.vistahealthplan.com: Request PCP change, view\print certificate of coverage, print a temporary ID card, a reimbursement form, referrals, advanced directives form, member handbook and member newsletter. Also, contact us via email regarding benefit questions, or claim issues.

METLIFE (800) 845-1870 - www.metlife.com/mybenefits: Find an in-network dentist, view your benefit summary, check the status and details of your claim. Register to receive automatic email alerts when your claim has been processed.

ADP & OHS (800) 432-3376 - www.compbenefits.com: Click "Member" icon, then "Contact", to find a participating dentist, request a new ID card, member materials, or other information.

Note: Benefit forms are also available through the County's employee portal. Access Group Life Beneficiary Designation, Flex Benefits Plan Status Change forms, MetLife Dental Claim, Optix Vision Claim, FSA Reimbursement form, Metlife DIsability, Evidence of Insurability forms and more.

Miami-Dade County Benefits Handbook

FBMC (800) 342-8017 - www.myFBMC.com
FBMC's Web site provides information regarding your benefits and comprehensive details on your Flexible Spending Account(s).

By entering www.myFBMC.com into your Internet browser, you will open FBMC's homepage. Answers to many of your Flexible Spending Accounts questions can be obtained by using the following navigational tabs located along the top portion of the home page.

Account Information
When you select the 'Account Information' tab, you'll be prompted to enter your Social Security number and Personal Identification Number (PIN). After this login, the following menu items will be available to you.

- Benefits- includes information on current benefits, such as effective date, number of deductions and pre-tax annual contribution
- Claims- provides information on open and current reimbursement claims such as date received, status and amount authorized
- Accounts - allows review of transactions from your current and previous plan years, including run-out period information, payment status and account availability
- Profile - helps you keep your personal information current, as well as manage your password and e-mail address
- Resources - gives you access to downloadable forms, such as FSA Reimbursement Requests and Direct Deposit forms, and FAQs

Downloading Forms
When you select the 'Download Forms' tab, a choice of forms, including a Letter of Medical Need, FSA Reimbursement Request Form and Direct Deposit Form, are posted for your convenience.

Frequently Asked Questions
The 'Frequently Asked Questions' tab provides answers to many of your general questions regarding Flexible Spending Accounts and enrollment information.

FBMC Customer Service
Clicking on the "Contact" tab gives you a direct link to the FBMC Customer Service Center

FBMC Interactive Benefits
FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). This system allows you to access your benefits any time. By following the voice prompts, you can find out a great deal of information about your benefits.

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your PIN

Personal Identification Number (PIN)
To access both the FBMC Web site and the Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first PIN, whether using the Web site or the IVR system. After your initial login, you will be asked to register and select your own confidential PIN to access both systems in the future. Your new PIN cannot be the last four digits of your SSN, as it was previously and cannot be longer than eight digits. If you forget your PIN, click the "I forgot my PIN" link for help. Once you've logged in, you may access information about your benefits.

Note: Please be sure to keep this Reference Guide in a safe, convenient place, and refer to it for benefit information.

Enrollment At A Glance

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. Section 817.234 (1) (b) (2000)

What's New for the 2007 Plan Year

- Unum Life Insurance Company will no longer be the provider for Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance. Metropolitan Life Insurance Company will be the new provider for the Short-Term and Long-Term Disability Insurance Plans effective January 1, 2007. The plan design has been enhanced for 2007 to give employees more choices in selecting the level of protection most suitable for their needs. The STD and LTD Plans both offer Low and High Option benefit levels. Employees may choose from one of two options offered for STD and/or one of two options offered for LTD. Biweekly employee premium deductions will be post-tax and based on the employee's salary, and option selected, rather than age as offered under Unum. All eligible employees not enrolled for STD and/or LTD coverage as of December 31, 2006 are eligible to enroll for Metlife disability coverage without submitting evidence of insurability. Coverage will become effective January 1, 2007 providing the employee is actively at work. See pages 24-26 of this Handbook for more details including disability premium information or visit the open enrollment website and click on the Help link. The personalized 2007 online enrollment screen will calculate your biweekly premiums for all disability options offered.
- If currently enrolled for STD and/or LTD coverage through UNUM and you wish to be enrolled for disability insurance for 2007, we encourage you to go online and select the plan(s) that best suits your needs. If you do not submit an online change, your benefit will be defaulted to the STD Low Option and/or LTD Low Option offered by Metlife and the appropriate premium contributions will be payroll deducted effective January 1, 2007. For example, if currently enrolled for Unum's STD and you do not submit a change online, your coverage will be defaulted to the $500 maximum benefit per week Metlife STD Low Option plan.
- AvMed, JMH and VISTA Health Plans will no longer require a referral from a primary care physician (PCP) to receive covered medical services from a participating plan specialist. See the plan literature, contact the plan or attend an open enrollment regional meeting for more details. In addition, AvMed encourages and facilitates its members to select a participating PCP but it is not required.
- The County will once again conduct online enrollment for the 2007 open enrollment period. This is a **"changes only"** open enrollment. Employees wishing to make a change to their current benefits or enroll/re-enroll for a Health Care and/or Dependent Care Spending Account for 2007 must utilize the website at ***www.miamidade.gov/OpenEnrollment*** to submit the request. At the end of the online enrollment process, you will be asked to complete a brief online survey to provide feedback on the online enrollment experience and materials provided.
- **Effective January 1, 2007, the timeframe to submit a change in status (such as marriage, divorce etc.) due to a qualifying event will be extended to 45 days (60 days to add newborns). See pages 35-36 Changing Your Coverage.**

Important Enrollment Information

- The 2007 online Open Enrollment period is October 30, 2006, through November 30, 2006. Online changes must be completed by November 30, 2006.
- Your 2007 Plan Year is January 1, 2007, through December 31, 2007.
- This is a changes-only enrollment. With the exception of your Flexible Spending Accounts (FSAs), all of your benefit selections will continue for the new plan year unless you decide to submit a change online. If you wish to participate in or continue a Healthcare and/or Dependent Care Flexible Spending Account you must submit the change online.
- All 2007 Plan Year benefit elections will become effective January 1, 2007 (other than new hires).
- New hires who become eligible after October 1, 2006, must submit enrollment paperwork to their DPR prior to their effective date of coverage. Contact your Departmental Personnel Representative for more details.
- In December, you will receive a confirmation notice for your Group Medical, Dental, Vision, Legal and Flexible Benefits Plan selections.
- If you have questions about your Flexible Benefits Health Care Spending Account or Dependent Care Spending Account, call Fringe Benefits Management Company (FBMC) Customer Service at 1-800-342-8017.
- Don't miss the regional meetings scheduled for October 30, 2006 through November 17, 2006. Look for the schedule on page 6 of this Handbook. Representatives from the following providers will be available to answer questions: Group Medical, Group Dental, Group Vision, Group Disability Income Protection, Group Legal and Deferred Compensation.
- The Open Enrollment period is an ideal time to review and update your beneficiary information. See your Departmental Personnel Representative to make beneficiary changes.
- Only changes resulting from **processing errors will be made after the Open Enrollment deadline**.

Regional Meeting Schedule

Regional Meeting Schedule October 30, 2007 - November 17, 2007

DATE	DAY	DEPT	LOCATION	ADDRESS	START	END
10/30/06	Mon	Solid Waste Mgmt	3A Garbage & NE Transf.	18701 NE 6th Ave.	7:30 AM	9:30 AM
10/30/06	Mon	Stephen P. Clark Ctr.	Lobby	111 NW 1st Street.	9:00 AM	1:00 PM
10/30/06	Mon	MDPD	HQ Cafetorium	9105 NW 25 St.	1:30 PM	4:00 PM
10/31/06	Tue	Seaport	Conference Rm, 5nd Floor	1007 N America Way	8:00 AM	10:00 AM
10/31/06	Tue	MDTA	Bus Op NE Garage, 1st Fl.	360 NE 185 St.	10:30 AM	12:30 PM
10/31/06	Tue	Park & Recreation	Gwen Cherry-Y.E.T. Center	7090 NW 22 Ave.	2:00 PM	3:30 PM
11/01/06	Wed	MDTA	Central Garage Driver's Rm, 1st FL	3300 NW 32 Avenue (Bus Ops.)	9:00 AM	11:00 AM
11/01/06	Wed	Public Works	Road, Bridge & Canal - Lunch Rm.	9301 NW 58th Street	3:00 PM	4:30 PM
11/02/06	Thu	ETSD	Break Room, 2nd Fl.	5680 SW 87 Ave.	8:00 AM	10:00 AM
11/02/06	Thu	Animal Services	Animal Care & Control - Lobby	7401 NW 74 St.	11:30 AM	1:00 PM
11/02/06	Thu	CorrectionsTGK Center	Lobby	7000 NW 41 Street	2:00 PM	4:00 PM
11/03/06	Fri	Water & Sewer	Douglas Rd Bldg. - Training Rm A&B	3071 SW 38 Avenue	9:00 AM	12:00 PM
11/03/06	Fri	Courts	Jury Pool Room, 7th FL	1351 NW 12 Street	2:30 PM	4:00 PM
11/06/06	Mon	Solid Waste Mgmt	3B Garbage & Trash	8000 SW 107 Ave.	7:30 AM	9:30 AM
11/06/06	Mon	Building Dept.	Permitting & Insp. Ctr, Conf. Rm I/J	11805 S.W. 26th Street (Coral Way)	8:00 AM	11:00 AM
11/06/06	Mon	Fire	Fire HQ - Lunch Rm.	9300 NW 41 St.	1:00 PM	3:00 PM
11/07/06	Tue	Aviation	Concourse A - Auditorium, 4th FL	Miami Intl. Airport	8:00 AM	11:00 AM
11/07/06	Tue	Stephen P. Clark Ctr.	Lobby	111 NW 1st Street	12:00 PM	3:30 PM
11/08/06	Wed	Human Services	Naranja Neigh.Ctr., Multi Purpose Rm	13955 SW 264 St.	9:00 AM	11:00 AM
11/08/06	Wed	MDTA	(Coral Way) Driver's Rm 1st FL	2775 SW 75 Ave	9:00 AM	11:00 AM
11/09/06	Fri	MDTA	Lehman Ctr, Conf. Rm A	6601 NW 72 Ave	9:30 AM	11:30 AM
11/09/06	Thu	Park & Recreation	Crandon Park Tennis Center	7300 Crandon Blvd.	11:30 AM	12:30 PM
11/09/06	Thu	Human Services	Elderly Home Care Program	4500 Biscayne Blvd	3:00 PM	5:00 PM
11/13/06	Mon	Solid Waste Mgmt	Main Pit Garbage & Trash	8831 NW 58th St	7:30 AM	8:30 AM
11/13/06	Mon	So. Dade Govt. Ctr.	Rm 203	10710 SW 211 St.	10:30 AM	12:30 AM
11/14/06	Tue	Water & Sewer	Westwood Lakes-Lunch Rm	4801 SW 117 Ave.	1:00 PM	3:30 PM
11/15/06	Wed	MDTA	NW Garage Driver's Rm 1st FL	8141 NW 80 Street (Medley)	9:00 AM	12:00 PM
11/15/06	Wed	Medical Examiner	Auditorium	NW 19 St.\10th Ave(#1 on B.Hope Rd)	2:00 PM	3:30 PM
11/16/06	Thu	Martin Luther King Bldg.	2nd Floor Conf Rm #3	2525 NW 62nd Street	8:00 AM	11:00 AM
11/16/06	Thu	ETSD	Break Room, 2nd Fl.	5680 SW 87 Ave.	2:00 PM	3:30 PM
11/17/06	Fri	Main Library-Downtown	Auditorium	101 West Flagler	9:00 AM	12:00 PM
11/17/06	Fri	Public Works	Traffic Signal & Signs	7100 NW 36 Street	2:00 PM	3:00 PM

Open Enrollment on the Web

This year, County employees who are making changes to their benefits or enrolling/re-enrolling for a spending account are once again required to enroll online.

No more long forms to fill out. No more guessing what your payroll deductions will be. Register online and it's all calculated for you! Need to add or delete dependents? Do it online. Need to enroll for or cancel coverage? Do it online.

All you need is 15-20 minutes of uninterrupted time so that you can make your elections. Then, print out your confirmation page for your record and you're done. If you need to go back and change your elections, no problem. As long as the enrollment period runs, you can make changes at ***www.miamidade.gov/OpenEnrollment***.

Before You Start

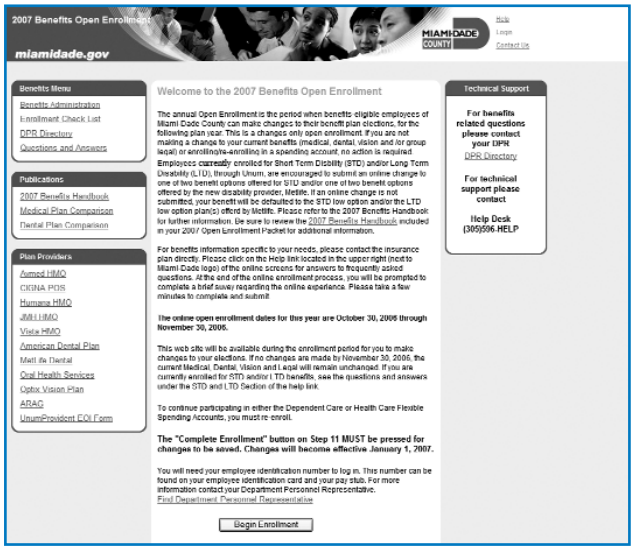
- Make sure you thoroughly review your enrollment materials. Most of these documents are online. If, after reviewing the materials, you still have questions, contact your Departmental Personnel Representative (DPR).
- Make sure you have all the applicable items in the open enrollment checklist handy.
  - **Employee Identification Number**. This 8-digit number can be found on the upper left corner of your pay stub or in most cases, your employee photo ID. You'll also need to know the last 4 digits of social security number the first time you log on.
  - **Primary Care Physician Number if changing plans or adding new dependents.**
  - Participating Dentist Number if changing to ADP or OHS or adding new dependents.
  - **Dependent Information** - this includes all eligible dependents' names and dates of birth.
  - **Spending Accounts** Amounts, if you are enrolling or re/enrolling.
  - **Coordination of Benefits** if you are covered by supplemental insurance or under your spouse's plan.

The 2007 online Open Enrollment period begins October 30 and ends November 30. You may change any elections you make at any time during the online Open Enrollment period.

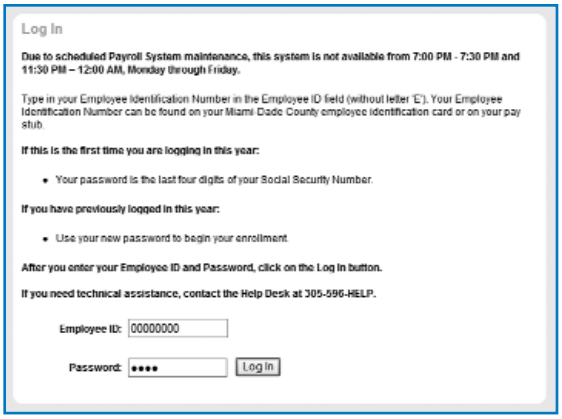
Logging On

Online enrollment is an 11-step process that must be completed in one session. If you log off before completing the final step, you will not be able to return to the place where you left off. Your changes will not be saved unless you press the Complete Enrollment button on Step 11. So, please be sure you have the 15 to 20 minutes it takes to complete all the steps.

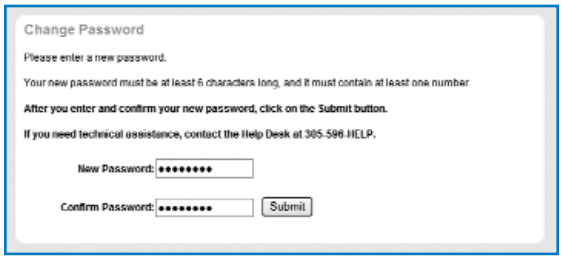
1. Go to intra.miamidade.gov and click "Open Enrollment" in the box labeled "Personnel." Or, go directly to ***www.miamidade.gov/OpenEnrollment***
2. At the welcome page, click "Begin Enrollment."



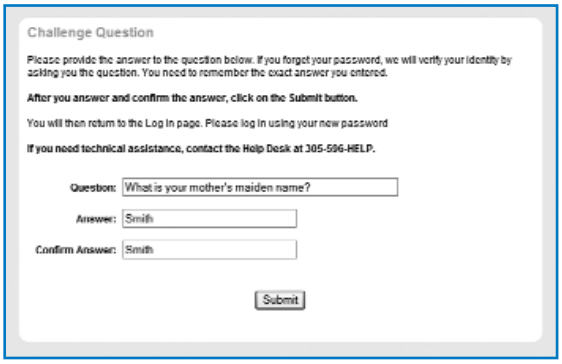
3. At the Open Enrollment Checklist click "Continue."
4. **The first time you log in,** enter your user name and password. Your username is your Employee ID Number. (Your Employee ID Number is the 8-digit number found on the back of your employee photo ID card or the upper left of your pay stub.) Example: 00001234. Your password is the last four digits of your Social Security Number.



You will then be prompted to change your password. Enter a new password. After you confirm your new password, click "Submit."



As an added security measure, you will then be asked a challenge question. After you confirm the answer, click "Submit."



A final log in will appear, enter your new password.

What's Online

Everything you need for online Open Enrollment can be found on the Open Enrollment Web site including:

- 2007 Benefits Handbook
- Links to provider Web sites
- Medical Plan Comparison
- Dental Plan Comparison
- Departmental Personnel Representative Directory

Need Technical Help

Call 305-596-HELP.

Eligibility Requirements

Period of Coverage

Your period of coverage is the same as the plan year, January 1, 2007, through December 31, 2007, unless you terminate employment, reduce hours worked, go on an unpaid leave of absence, change your pre-tax benefit elections through a valid Change in Status or change your post-tax benefits.

Who is eligible for group benefits?

- Any full-time, regular Miami-Dade County employee who has completed 90 days of employment is eligible. Coverage becomes effective the first of the month following or coincident to 90 days of employment provided timely election is made. To enroll for group benefits, eligible employees must complete an election form and submit it through their DPR's office the month prior to the employee's eligibility date. It is the employee's responsibility to follow-up with his\her DPR to obtain the election form if one is not provided within one month of the eligibility date.
- Any part-time employee who consistently works at least 60 hours biweekly and has completed 90 days of employment is eligible. Coverage becomes effective the first of the month following or coincident to 90 days of employment provided timely election is made. The part-timer must continue to satisfy the minimum number of working hours requirement to remain eligible for benefits.
- Employees must be actively at work for disability or group life benefits to become effective.
- All employees are eligible to participate in the deferred compensation plan.
- Upon certain Qualifying Events, ex-spouses, children who cease to be dependents, employees going from full-time to part-time status and dependents of a deceased employee may be eligible for coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA).
- For questions regarding your eligibility for group medical, dental, vision, life insurance, disability and group legal, or to participate in a flex spending account, contact your Departmental Personnel Representative.

New Employees

New hires who become eligible on or after October 1, 2006, must submit enrollment paperwork directly to their Departmental Personnel Representative prior to their effective date of coverage. Remember to include proof of dependent eligibility if applying for dependent coverage. Contact your Departmental Personnel Representative for more details.

Special Enrollment Rights Pertaining to Medical Benefits

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in your employer's plan provided that you request enrollment within **forty-five (45) days** after the other coverage ends.

Employees on Leave

If you participate in any of the benefits offered by Miami-Dade County and go on an approved leave of absence, or if you are in a "no-pay status" due to worker's compensation or suspension from work, it will affect your participation in the benefit plans. You are required to continue making payments to maintain insurance coverage. Contact your Departmental Personnel Representative for detailed information. See the Leave of Absence Q&A section of this Benefits Handbook for further details.

Terminating Employees (Except Retirement)

If you are a terminating employee, you can continue certain benefits by contacting the following providers within 60 days of your termination of employment:

- the FBMC Customer Service Department at 1-800-342-8017 to apply for continuation, on an after-tax basis, of your Healthcare FSA. If you elect to continue your Healthcare FSA through COBRA, you can be reimbursed for expenses incurred through the end of the plan year (December 31, 2006) or until you exhaust your account balance. If you choose not to continue your Healthcare FSA through COBRA, you can only be reimbursed for expenses incurred within your period of coverage.

NOTE: Your employer's Healthcare FSA Plan is not subject to COBRA continuation beyond the end of the plan year in which a COBRA-qualifying event occurs.

- Dependent Care FSA cannot be continued.
- You may contact ARAG directly if interested in purchasing a group legal conversion policy. Note, the plan benefits and rates may differ under a conversion policy.
- If you are currently enrolled in: Medical, Dental and/or Vision coverage, the health plans will notify you of your COBRA continuation rights.

Flex Dollars and Flexible Benefits

Miami-Dade County strives to provide competitive employee benefits. For the 2007 Plan Year, the County will continue to provide every employee eligible for benefits with $1,000 in Flex Dollars.

The County also provides you with several healthcare options and additional cash incentives. If you choose to enroll in an HMO for your medical coverage, you will receive additional Flex Dollars.

By enrolling in:
- AvMed, Humana or JMH Healthplan, you receive an extra $130 in Flex Dollars per year, or $5 per pay period.
- Vista Health Plan, you receive an extra $260 in Flex Dollars per year, or $10 per pay period.

What can you buy with Flex Dollars?

Flex Dollars can be used to pay the premiums for any of these pre-tax benefits:
- Dependent medical premiums
- Dependent dental premiums
- Enriched dental premiums
- Vision plan premiums
- Health Care Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (FSA)

You do not have to participate in the group medical, group dental or group vision plan to receive Flex Dollars.
When using Flex Dollars to purchase your benefits, your Federal Income and Social Security taxes are reduced, allowing you to keep more of your take-home pay.

If you use all of your Flex Dollars in selecting pre-tax benefits, you can elect to pay for any remaining eligible benefits from your pre-tax salary. In this case, premiums for your remaining pre-tax benefits will be taken directly from your pay before taxes. This lowers the amount of your taxable income; as a result, you pay less in taxes!

Another option is to use your Flex Dollars as taxable income. If you do not spend your Flex Dollars on pre-tax flexible benefits, they will be converted to taxable income (subject to federal withholding and Social Security taxes). You can use this taxable income to enroll in Group Legal Services, STD or LTD Disability benefits or you can consider part or all of the taxable income as a way to increase your contributions to the Deferred Compensation Plan.

Enrollment for 2007

Because Miami-Dade County's enrollment is a changes-only enrollment, all of your benefit selections from 2006 (**excluding** Healthcare and Dependent Care FSAs) will continue for the new plan year. However, if you would like to make a change to your benefit selection, continue your Flexible Spending Accounts or enroll in a new benefit, you must enroll or make the change online.

What are the Flexible Benefits Plan Administrative Fees per pay period?

Healthcare Spending Account.only..... $1.96
Dependent Care Spending Account only..... $1.96
Healthcare and Dependent Spending Accounts..... $1.96

Appeals Process for Denied FSA Claims

If you have a request for an FSA reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to FBMC.

Your appeal must include:
- the name of your employer
- the date of the services for which your request was denied
- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied and
- any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon receipt of it and its supporting documentation. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

Group Medical Plans

As an eligible Miami-Dade County employee, you may choose from five different medical plans:

- **CIGNA HealthCare, Point of Service** (POS)
- **AvMed HMO** (No referrals from PCP, are required to receive covered medical services from participating specialists)
- **Humana HMO** (Referrals, from PCP, are required to receive covered medical services from participating specialists)
- **JMH Health Plan HMO** (No referrals, from PCP, are required to receive covered medical services from participating specialists)
- **VISTA HMO** (No referrals, from PCP, are required to receive covered medical services from participating specialists)

A Point of Service (POS) plan allows you to receive services from an in-network or out-of-network provider of your choice. In-network, the "Primary Care Physician" (PCP), chosen by you, manages all healthcare and refers you to specialists based on medical necessity. If you choose an out-of-network physician, your healthcare services will be subject to the plan deductible and co-insurance provisions.

A Health Maintenance Organization (HMO) provides a wide range of healthcare services to you on a prepaid basis. Under this plan, you receive medical services at no cost or for a moderate co-payment-without deductibles or claim forms. Under Humana, a "Primary Care Physician" (PCP) manages all healthcare and refers you to specialists based on medical necessity. Although VISTA and the JMH Health Plans still require you to select a participating PCP, you will not be required to get a referral from your PCP to receive care for covered medical services from participating specialists. AvMed encourages and facilities PCP selection, but it is not required. Services other than those due to an emergency must be received by a participating network provider within the plan service area which is primarily in the South Florida area (Miami-Dade, Broward and Palm Beach Counties).

If you enroll in AvMed, Humana or the JMH Health Plan, you will receive an additional $5 in Flex Dollars per pay period. If you enroll in Vista, you will receive an additional $10 in Flex Dollars per pay period.

Union Plan: Members of the DCFF fire union may be eligible for coverage in their Union-sponsored plan. Contact your Union office for further details.

Who are Eligible Dependents?

The following dependents are eligible for Group Medical, Group Dental and/or Group Vision coverage:

- Your spouse, as recognized by the State of Florida, unless also an eligible County or Public Health Trust employee.
- Your unmarried natural child (including a newborn), stepchild, foster child, adopted child (including a newborn child who is required to be eligible for membership as an adopted child in conformity with applicable law) or a child for whom the employee has been appointed legal guardian, pursuant to a valid court order, and the child is under the limiting age. The eligibility limiting age of an unmarried dependent child is the end of the calendar year in which the child reaches age 19. Coverage (except for Foster children in court-ordered custody or guardianship of the employee) may be extended until the end of the calendar year in which the dependent child reaches age 25, if all of the following requirements are met: a.) the unmarried child is primarily dependent upon the employee for financial support and b.) the unmarried child is living in the household of the employee or the unmarried child is a full-time or part-time student. Employees are required to provide the health plan by January 31 acceptable documentation that the child meets and continues to meet such requirements. Failure to provide acceptable documentation will result in cancellation of the dependent's medical, dental, vision coverage (if enrolled). Acceptable proof that the child continues to meet the eligibility criteria beyond age 19 may include:
  a.) completed tax return for prior year or affidavit of support and
  b.) proof of student status or
  c.) proof the child resides in your household.
- Coverage for an unmarried dependent child may be continued beyond age 25 (coverage must begin before age 25) if they are incapable of sustaining employment because of mental or physical disability, and are chiefly dependent upon the employee for support. Proof of disability will be required by the health plan.

The health plans will continue to screen for the eligibility of dependents with last names that differ from yours and for the eligibility to continue benefits for dependent children beyond the limiting age of 19 years. This process will help us ensure that ineligible dependents are not being covered, and costing the plan (and you) money. Failure to provide the information will jeopardize the coverage of your dependent(s). Please see below this Benefits Handbook for the criteria for dependent eligibility and the documentation required.

Type of Documentation Required by Dependent Type

Spouse	Copy of official certified or registered Marriage Certificate (religious certificates are not acceptable)
Child(ren)	Copy of official Birth Certificate(s) showing employee as parent (birth cards are not acceptable)
Stepchildren	Copy of official Birth Certificate(s) **AND** copy of official State certified or registered Marriage Certificate
Child(ren) under Legal Guardianship, Custody or Foster Care	Copy of Legal Guardianship/Custody document from the Courts or copy of Foster Care documentation from Courts.
Child(ren) adopted or child(ren) in the process of adoption	Copy of Legal Adoption documentation showing relationship to employee and placement in employee's home or copy of Adoption Certificate issued through the Courts.
*Grandchild(ren) **OR** other child not related	Copy of official Birth Certificate(s) of child(ren) **AND** copy of Legal Guardianship, Adoption or Foster Care document from the Courts.

* A dependent of a dependent (child born to an enrolled child dependent) may remain on the plan for up to 18 months from the date of birth. After 18 months, the dependent of the dependent must meet the criteria of legal guardianship by the employee or spouse.

Is coverage guaranteed?

During Open Enrollment eligible employees and their dependents are guaranteed enrollment in any of the County-sponsored medical plans. Eligible new hires and their dependents are also guaranteed coverage in any of the County-sponsored medical plans if they enroll during their initial eligibility period. Coverage is also guaranteed if you enroll yourself and/or your dependents within **45 days** of a Change In Status (60 days for newborns), or if you qualify under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). See the Changing Your Coverage section for more information on Changes In Status and HIPAA.

For additional information on medical plans and rates, refer to your Benefit Comparison Chart included in this Benefits Handbook, visit the plan's website or contact the plans directly at the numbers provided for information specific to your needs.

If you have medical coverage, your co-payments or uninsured, out-of-pocket expenses may be eligible for reimbursement through your Healthcare FSA. See Page 29 for a partial list of eligible expenses or call FBMC Customer Service at 1-800-342-8017.

Group Dental and Group Vision Plans

Group Dental Plan

You may enroll yourself and your eligible dependents for dental coverage even if you don't elect medical coverage. You may choose the plan that best suits your needs:

- MetLife's Standard or Enriched Dental Indemnity plan
- American Dental Plan's Standard or Enriched Dental prepaid plan
- Oral Health Services' Standard or Enriched Dental Prepaid plan

- **Indemnity:** Standard or Enriched. Select the dentist of your choice. Benefits are payable at various coinsurance levels. A deductible is applied for services other than preventive and diagnostic. Annual maximum reimbursements are: $1,000 per person for the Standard plan and $1,500 per person for the Enriched plan. The Enriched plan also includes orthodontia.

- **Prepaid:** Standard or Enriched. Choose a plan dentist from a list of participating dentists and receive coverage for a variety of services. Participating dentists are primarily in the South Florida Tri-county area. Most preventive, diagnostic and many other services are provided at no additional cost to members. Some services have fixed co-payments. There are no claim forms, no deductibles and no annual dollar maximum under the prepaid dental programs. The Enriched Prepaid Dental plan provides additional benefits and specialty coverage not covered under the Standard program.

Services must be received by a participating provider within the plan's service area.

Group Vision Plan

VisionCare, Inc. (VCI), a subsidiary of CompBenefits, offers the Optix pre-paid vision plan to all employees eligible for medical and dental coverage regardless of union affiliation. Employees pay the full cost of the program. You and your enrolled dependents, if any, will receive an annual comprehensive eye exam at no charge with a participating optometrist or ophthalmologist. Members may also receive a pair of glasses every year, with a $10 copay, from a special selection of frames available at participating providers. Contact lenses or other frames are available as alternate benefits. This program allows you to use non-participating providers and be reimbursed according to the non-participating benefit schedule. See the Optix plan literature for plan benefits, limitations and rates.

Please see page 10 for dependents eligible to participate in group dental and vision benefits.

Union Plan

If you are enrolled in the DCFF Fire Union-sponsored health plan, you may elect coverage through the Optix vision plan, but you cannot participate in any County-sponsored dental program.

Is coverage guaranteed?

You are guaranteed group dental and group vision coverages as long as you enroll during Open Enrollment, during your initial eligibility period, within **45 days** of a Change In Status (60 days for newborns), or if you are qualified under HIPAA.

For additional information on dental plans and rates, refer to your Benefit Comparison Chart included in this booklet or contact the plan.

For additional information on Optix vision benefits and rates, refer to the Optix Plan literature or contact the plan.

What you can expect:

- Immediate savings
- Convenient locations
- Quality professional care and services
- No complicated forms to fill out
- No long waits for rebates
- Out-of-network benefits

Easy as 1-2-3...

1. Look for the Optix Benefit Brochure at the enrollment sessions and remember to elect Optix coverage on your enrollment form if you are not currently enrolled.
2. When you are ready for services, call one of the Optix providers listed in your benefits brochure.
3. Identify yourself as an Optix member and sign the benefits form at the time of your appointment.

That's all you do. We do the rest!

Get More Information

For more about this plan and how it works, get in touch with Optix by calling the toll-free number: 1-800-EYE-CURE.

If you have dental or vision coverage, your co-payments or uninsured out-of-pocket expenses may be eligible for reimbursement through your Healthcare FSA. See Page 30 for a partial list of eligible expenses or call FBMC Customer Service at 1-800-342-8017.

2007 Bi-Weekly Employee Rates

MEDICAL

	Employee Contribution
CIGNA HealthCare	
Employee Only	$10.49
Employee + one	$318.10
Employee + 2 or more	$437.85
AvMed	
Employee Only	$0.00
Employee + one	$163.23
Employee + 2 or more	$221.41
Humana	
Employee Only	$0.00
Employee + one	$182.21
Employee + 2 or more	$246.38
JMH	
Employee Only	$0.00
Employee + one	$162.29
Employee + 2 or more	$220.20
Vista Healthplan	
Employee Only	$0.00
Employee + one	$147.63
Employee + 2 or more	$199.61

DENTAL

	Employee Contribution	
	Standard	Enriched
Met Life		
Employee Only	$0.00	$4.68
Employee + one	$14.82	$24.07
Employee + 2 or more	$33.16	$48.09
American Dental Plan		
Employee Only	$0.00	$1.25
Employee + one	$2.60	$4.69
Employee + 2 or more	$6.09	$9.80
Oral Health Services		
Employee Only	$0.00	$1.25
Employee + one	$2.60	$4.69
Employee + 2 or more	$6.09	$9.80

Optix Vision	
Employee only	$2.30
Employee + one dependent	$4.60
Employee + two or more dependents	$8.48

Please check your pay stub on January 5, 2007 to insure the correct deduction was taken. Contact your DPR no later than January 12, 2007 if there are any processing errors.

CIGNA (POS) Plan

	CIGNA HEALTHCARE (POS) (This Plan Allows You To Use Both In And Out Of Network Providers. For Purposes Of This Summary, The Two Will Be Discussed Separately.) Visit our website at www.Cigna.com	
COVERAGE PLAN DESCRIPTION	**IN NETWORK** A managed care program which offers employees, covered dependents and retirees (under age 65) the ability to use selected hospitals and doctors, with 100% benefits for covered charges, after applicable co-payments. You select a primary care physician who manages your healthcare needs within the network.	**OUT OF NETWORK** A fee for service program that provides you the freedom to use any physician or accredited hospital of your choice without going through a primary care physician (PCP). Payments are based on reasonable and customary (R & C) charges. Providers who do not participate in CIGNA's network may balance bill you for the amount which exceeds R & C. Coverage is subject to deductibles and co-insurance.
DEDUCTIBLES/ COPAYMENTS	Co-payments $10 Physician office visit $50 Emergency Room (waived if admitted) $5/$10/$15 Prescriptions for 30 day supply Mail Order: $10/$20/$30 for 90 day supply.	Deductible $200 per individual; $500 per family $50 Emergency Room Co-payment (waived if admitted) Same in-network prescription benefits apply if participating pharmacy is used. See below for clarification.
PHYSICIANS	Choose any primary care physician from CIGNA HealthCare participating provider list. Covered family members may choose their own primary care physician.	Choose any licensed physician; covered charges payable at 70% of reasonable & customary (R & C) after deductible.
A. IN-HOSPITAL PHYSICIAN SERVICES: **Surgery/Visits & Consultations** **Anesthesiologist**	Benefits payable at 100% when received at participating hospitals and arranged by the member's primary care physician.	Benefits payable at 70% reasonable & customary (R & C) covered charges, after deductible is met.
B. OUT-PATIENT PHYSICIAN SERVICES:		
Office visits for illness	$10 co-payment; then 100%	70% of R & C covered charges, after deductible is met.
Office visits for injury	$10 co-payment; then 100%	70% of R & C covered charges, after deductible is met.
Diagnostic X-Rays, Lab Tests, X-Ray treatments	100%	70% of R & C covered charges, after deductible is met.
Pediatrician		
1) Medically Necessary	$10 co-payment; 100% thereafter.	70% of R & C covered charges, after deductible is met.
2) Preventive (Child Health Supervision Services)	$10 co-payment; then 100% Covers one visit per calendar year for all services provided up to age 16.	100% of R & C covered charges, no deductible.
Routine Physical	$10 co-payment; then 100%	Not covered
Obstetrical/Gynecological	$10 co-payment, then 100%. PCP referral not required. Mammograms, PAP smears payable at 100%	70% of R & C covered charges, after deductible is met.

CIGNA (POS) Plan

	CIGNA HEALTHCARE (POS) (This Plan Allows You To Use Both In And Out Of Network Providers. For Purposes Of This Summary, The Two Will Be Discussed Separately.) Visit our website at www.Cigna.com	
Hospitalization: ***Note: These hospitals are not full service hospitals but are contracted for specialty or specific services only.**	Benefits payable at 100% at following affiliated hospitals when admitted with PCP authorization: **MIAMI-DADE COUNTY** Aventura • Baptist • Cedars • Coral Gables • Health South Doctor's Hospital • Hialeah • Kendall Regional • Mercy • Miami Children's • Miami Heart • Mt. Sinai • Miami Heart •North Shore • Palmetto General • Parkway Regional • SMH Homestead • South Miami • University of Miami/Jackson Memorial Hospital and Clinics • Villa Maria Rehab Hospital* **BROWARD COUNTY** Broward General • Cleveland Clinic* • Coral Springs • Florida Medical • Hollywood Medical • Holy Cross • Imperial Point • Memorial of Miramar • Memorial of Pembroke • Memorial Regional • Memorial West • North Broward • North Ridge • Northwest Medical Center • Plantation General • St. Anthony's Rehab* • University Hospital • Westside Regional	70% of R & C covered charges, after deductible is met.
Hospital/Surgical Requirements: Precertification of hospital confinements	Handled by admitting physician.	Precertification required or benefits will result in a $500 penalty. This is the responsibility of the member, not the providers.
Drug & Alcohol Treatment: **Inpatient** **Outpatient**	$25 per inpatient day. Maximum of **45 days** annually. $10 co-payment, up to 30 outpatient visits per calendar year.	Benefits payable at 70% of R & C, after deductible is met. Maximum of **45 days** annually. 70% of R & C charges after deductible is met to a maximum of 30 visits per calendar year.
Mental & Nervous Disorders: **Inpatient** **Outpatient**	100%. Maximum of **45 days** annually. $10 co-payment, up to 30 outpatient visits per calendar year.	Benefits payable at 70% R & C covered charges, after deductible is met. Maximum of **45 days** annually. 70% of R & C charges after deductible is met to a maximum of 30 visits per calendar year.
Other Services **Ambulance** **Vision**	100% Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams, glasses, contact lenses not covered.	70% of R & C charges after deductible is met. Coverage provided for diseases of the eye and/or injuries to the eye at 70% of R & C after deductible is met. Eye exams, glasses, contact lenses not covered.

CIGNA (POS) Plan

	CIGNA HEALTHCARE (POS) (This Plan Allows You To Use Both In And Out Of Network Providers. For Purposes Of This Summary, The Two Will Be Discussed Separately.) Visit our website at www.Cigna.com	
Prescription Drugs:	$5 Generic/$10 Preferred Brand/$15 Non-Preferred Brand prescriptions for 30 day supply including prescription contraceptives at participating pharmacies such as Eckerd, Walgreens, Publix, Navarro, Sedanos, Albertson's, Wal-Mart and Winn Dixie. See plan literature for other participating pharmacies. Mail order: 2x copay for 90-day supply.	$5 Generic/$10 Preferred Brand/$15 Non-Preferred Brand prescriptions for 30 day supply including prescription contraceptives at participating pharmacies such as Eckerd, Walgreens, Publix, Navarro, Sedanos, Albertson's, Wal-Mart and Winn Dixie. Mail order: 2x copay for 90-day supply. See plan literature for other participating pharmacies. Deductible +30% of charges apply at non-participating pharmacies.
Durable Medical Equipment (DME):	Covered at 100%.	70% of R & C charges after deductible is met.
Out of Area: **1) Emergency** **2) Non-Emergency**	$50 co-pay, waived if admitted/100%. 70% of R & C charges after deductible is met.	$50 co-pay, waived if admitted/100%. 70% of R & C charges after deductible is met.
	Maximum lifetime benefits is unlimited in-network, $1 million out-of-network. Out-of-network annual out-of-pocket maximum is $1,500 per individual for participating providers in the traditional network, no family maximum. Non-participating out-of-network providers have not agreed to accept CIGNA's reasonable and customary standard (R & C) as payment in full for covered services. Therefore, if a non-participating provider is used the insured is also responsible for the difference between R & C and the non-participating provider's actual charges.	

AVMED & HUMANA (HMO) Plans

	AVMED HEALTH PLAN (HMO) Visit our website at www.avmed.org/go/mdpht	HUMANA (HMO) Visit our website at www.humana.com
COVERAGE PLAN DESCRIPTION	A not for profit Health Maintenance Organization with a large network of providers in the State of Florida. We offer a broad range of medical services at participating private physician offices. Members are encouraged, but not required, to select a primary care physician from the participating provider network which includes over 40 hospitals as well as over 2,800 specialists in Miami-Dade and Broward County. No referrals needed to see participating specialists. Other features include 24 hour Member Service, Nurse on Call hot lines, Care Management programs, discounted Mail Order Prescriptions.	Humana Inc., is one of the nations largest health services companies. Its South Florida Health Maintenance Organization provides primary and specialty services throughout it's network of over 1,300 primary care physicians, 4,500 specialists, and 51 hospitals. Employees must select a primary care physician from the participating provider network. Other features include award-winning chronic conditions management programs, mail-order prescription services, and HumanaFirst, a 24-hour medical information hotline.
DEDUCTIBLES/ COPAYMENTS	Co-payments $10 Physician office visit $25/$50 Emergency Room (not waived if admitted) $10/$20/$30 prescription for 30-day supply based on formulary $20/$40/$60 Mail order prescriptions available for 90-day supply based on formulary	Co-payments $10 Physician office visit $25 Emergency Room (waived if admitted) $7/$15/$25 prescription for 30-day supply based on formulary $21/$45/$75 Mail order prescriptions available for 90-day supply based on formulary
PHYSICIANS	Choose any primary care physician from the participating provider net work, but it is not required.	Physicians services are covered in full when provided or arranged by one of our over 1100 primary care physicians, chosen from our participating provider directory.
A. IN-HOSPITAL PHYSICIAN SERVICES: **Surgery/Visits & Consultations** **Anesthesiologist**	Benefits payable at 100% when received at participating hospitals and arranged by the member's primary care physician.	Benefits payable at 100% when received at participating hospitals and arranged by the member's primary care physician.
B. OUT-PATIENT PHYSICIAN SERVICES: **Office visits for illness**	$10 co-payment; then 100%	$10 co-payment per visit, then 100% (PCP) -100%, no co-payment (specialist)
Office visits for injury	$10 co-payment; then 100%	$10 co-payment per visit, then 100% (PCP) -100%, no co-payment (specialist)
Diagnostic X-Rays, Lab Tests, X-Ray treatments	100%	$10 co-payment per visit, then 100% (PCP) -100%, no co-payment (specialist)
Pediatrician **1) Medically Necessary**	$10 co-payment; 100% thereafter.	1) $10 co-payment per visit, then 100% (PCP); no co-payment (specialist)
2) Preventive (Child Health Supervision Services)	$10 co-payment; 100% thereafter.	2) $10 co-payment per visit, then 100%
Routine Physical	$10 co-payment; 100% thereafter for annual exam.	$10 co-payment per visit, then 100%. Limited to one (1) exam per calendar year for adult physical exam.
Obstetrical/Gynecological	$10 Co-pay for one routine GYN exam allowed each calendar year without referral. Mammogram screening provided at 100%.	$10 co-payment per visit, then 100% (PCP); no co-payment (specialist). Limited to (1) exam per calendar year. Mammograms are covered at 100%.

	AVMED HEALTH PLAN (HMO) Visit our website at www.avmed.org/go/mdpht	HUMANA (HMO) Visit our website at www.humana.com
Hospitalization: ***Note: These hospitals are not full service hospitals but are contracted for specialty or specific services only.**	Benefits payable at 100% at following affiliated hospitals: **MIAMI-DADE COUNTY** Anne Bates Leach • Aventura • Baptist • Cedars • Coral Gables • Health South Rehab* • Hialeah • Homestead • Kendall Regional • Larkin • Mercy • Miami Children's • Mt. Sinai • North Shore • Palm Springs • Palmetto General • Parkway Regional • South Miami • Doctors Hospital • St. Catherine's Rehab* • University of Miami/Jackson Memorial Hospital & Clinics • Windmoor **BROWARD COUNTY** Broward General • Cleveland Clinic* • Coral Springs • Florida Medical • Hollywood Medical • Holy Cross • Imperial Point • Memorial of Miramar • Memorial of Pembroke • Memorial Regional • Memorial West • North Broward • North Ridge • Northwest Medical Center • Plantation General • St. Anthony's Rehab* • University Hospital • Westside Regional	Benefits payable at 100% at following affiliated hospitals: **MIAMI-DADE COUNTY** Anne Bates Leach • Aventura • Baptist • Cedars • Coral Gables • Hialeah • Homestead • Jackson Memorial • Jackson South • Kendall Regional • Kindred • Mercy • Miami Children's • Miami Heart • Mount Sinai • North Shore • Palm Springs • Palmetto General • Pan American • Parkway • South Miami • UM Sylvester **BROWARD COUNTY** Broward General • Cleveland Clinic* • Coral Springs • Florida Medical • Fort Lauderdale* • HealthSouth Sunrise • Hollywood Medical • Holy Cross • Joe DiMaggio Children's • Kindred* • Memorial Miramar • Memorial Pembroke • Memorial Regional • Memorial West • North Broward • North Ridge • Northwest • Plantation General • University • Westside
Hospital/Surgical Requirements: Precertification of hospital confinements	All non-emergency inpatient confinements and physician/surgeon charges are preauthorized through AvMed	All non-emergency confinements and physician/surgeon charges are precertified through Humana Medical Plan, Inc.
Drug & Alcohol Treatment: **Inpatient** **Outpatient**	Covered at 100% up to 30 residential inpatient days per year. ***Acute or crises intervention only. Covered at 100% up to a maximum of 60 calendar days, limited to 2 program completions per lifetime. Inpatient/outpatient maximum 60 calendar days.	Covered at 100% for medically necessary detoxification. Covered at 100% for detoxification. Excluding detoxification, other services limited to lifetime maximum of 44 visits. Member is responsible for all amounts over $35 per visit.
Mental & Nervous Disorders: **Inpatient** **Outpatient**	Covered at 100% up to 30 inpatient days per year with plan approval. *** Acute or crises intervention only. $5 co-payment up to 30 outpatient visits per year.	Covered at 100% up to 30 days per calendar year. $10 co-payment per visit, then 100%. Limited to 20 visits per calendar year.
Other Services **Ambulance** **Vision**	100% when medically necessary. $10 co-payment, 100% thereafter for eye exams for children under age 18. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory.	100% when medically necessary. No co-payment for one eye exam per 12 month period; $10 dispensing fee for eyeware. 100% coverage of standard lenses and frames up to $34 value. Co-payments vary for contacts in lieu of eyeglasses.

	AVMED HEALTH PLAN (HMO) Visit our website at www.avmed.org/go/mdpht	HUMANA (HMO) Visit our website at www.humana.com
Prescription Drugs:	$10 Generic/$20 Brand/$30 Non-Preferred for a 30-day supply at participating pharmacies including prescription contraceptives. Mail order: $20 Generic/$40 Brand/$60 Non-Preferred for a 90-day supply. If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment.	$7 Level One/$15 Level Two/$25 Level Three 30-day supply at participating pharmacies including prescription contraceptives. Mail order: $21 Level One/$45 Level Two/$75 Level Three for 90-day supply. If member selects a brand drug when a generic is available, member pays the difference in cost plus the applicable generic co-pay.
Durable Medical Equipment (DME):	$50 co-payment per episode of illness. Limited to a maximum of $500 per contract year. Prosthetic devices are covered. Please refer to brochure for limitations and restrictions.	Covered at 100%
Out of Area: **1) Emergency** **2) Non-Emergency**	100% after $50 co-payment (worldwide). Not covered.	1) $25 co-pay for life threatening emergencies. 2) Not covered.
	** See plan literature for a complete list of benefits and information regarding purchase of non-Generic drugs. *** Coverage for inpatient drug/alcohol and mental & nervous disorders maximum 30 days per contract year.	**See plan literature for complete list of benefits.

	JMH HEALTH PLAN (HMO) Visit our website at www.jmhhp.com	VISTA HEALTH PLAN (HMO) Visit our website at www.vistahealthplan.com
COVERAGE PLAN DESCRIPTION	A not-for-profit Health Maintenance Organization headquartered in Miami-Dade County, the JMH Health Plan is a full-service plan offering health care through a broad and extensive network of over 2,700 physicians and 30 hospitals in Miami-Dade and Broward Counties and featuring the University of Miami / Jackson Memorial Medical Center. The JMH Health Plan has served Miami-Dade County for 20 years and consistently ranked among the top HMO's in member satisfaction in both the Florida HMO Report Card, and the Miami-Dade County Employee Health Survey. * The JMH Health Plan does not require referrals from PCPs to receive covered medical services from participating specialists.	A for profit Health Maintenance Organization with an extensive network of Primary and Specialty Care Providers and Hospitals. As one of the largest and oldest HMO's in the country, VISTA is committed to providing access to quality health care services and to promoting healthy lifestyles to its members through prevention and early treatment of disease. Employees must select a primary care physician from the participating provider network, but have direct access to all in network specialist without a referral.
DEDUCTIBLES/ COPAYMENTS	Co-payments $10 Physician office visit $50 Emergency Room (waived if admitted) $7/$20/$35 Prescriptions for 30 day supply - Open Formulary Mail Order: $14/$40/$70 for 90 day supply	Co-payments $10 Physician office visit* $25 Emergency Room (waived if admitted) $10/$20/$30 Prescriptions for 30 day supply based on formulary $20 Generic/$40 Brand Mail order prescriptions available for 90 day supply
PHYSICIANS	Choose any physician from the network of over 900 primary care physicians in Miami-Dade and Broward counties.	Choose any primary care physician from VISTA's participating provider list. Covered family members may choose their own primary care physician.
A. IN-HOSPITAL PHYSICIAN SERVICES: **Surgery/Visits & Consultations** **Anesthesiologist**	Benefits payable at 100% when provided or arranged by the JMH Health Plan.	Benefits payable at 100% when received at participating hospitals and arranged by the member's primary care physician.
B. OUT-PATIENT PHYSICIAN SERVICES:		
Office visits for illness	$10 co-payment per visit, 100% thereafter	$10 co-payment per visit, 100% thereafter.
Office visits for injury	$10 co-payment per visit, 100% thereafter	$10 co-payment per visit, 100% thereafter.
Diagnostic X-Rays, Lab Tests, X-Ray treatments	100% when provided or arranged by JMH Health Plan.	100% when coordinated by your Vista Primary Care Physician.
Pediatrician **1) Medically Necessary**	1) $10 co-payment per visit.	1) $10 co-payment per visit
2) Preventive (Child Health Supervision Services)	2) $10 co-payment per visit.	2) 100%, no co-payment.
Routine Physical	$10 co-payment per visit.	$10 co-payment per visit.
Obstetrical/Gynecological	$10 co-payment per visit. No referral for 1st OB/GYN visit	$10 co-payment Annual Well Women Exam without referral. All other OB/GYN visits require a referral, $10 co-payment per visit.

	JMH HEALTH PLAN (HMO) Visit our website at www.jmhhp.com	VISTA HEALTH PLAN (HMO) Visit our website at www.vistahealthplan.com
Hospitalization: ***Note: These hospitals are not full service hospitals but are contracted for specialty or specific services only.**	Benefits payable at 100% at following affiliated hospitals: **MIAMI-DADE COUNTY** Anne Bates Leach • Aventura • Baptist • Cedars • Coral Gables Hospital • Doctors Hospital • Hialeah Hospital • Jackson Memorial Hospital • Homestead Hospital • Holtz Children's Hospital UM/JM Medical Center • Jackson South Community Hospital • Kendall Regional • Miami Children's • North Shore • Palmetto General • Parkway Regional • South Miami • University of Miami/ Hospital & Clinic **BROWARD COUNTY** Florida Medical Center • Hollywood Medical Center • Joe DiMaggio Children's Hospital • Memorial Hospital Miramar • Memorial Hospital Pembroke • Memorial Hospital West • Memorial Regional • North Ridge Medical Center • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center	Benefits payable at 100% at following affiliated hospitals: **MIAMI-DADE COUNTY** Anne Bates Leach • Aventura • Baptist • Cedars Medical • Coral Gables • Jackson South • Health South Doctors Hospital • Hialeah • Kendall Regional • Mercy • Miami Children's • Miami Heart Institute-South • Mt. Sinai • North Shore • Pan American Hospital Palmetto • Palm Springs General Hospital • General • Parkway Regional • SMH Homestead • South Miami • South Shore • University of Miami/Jackson Memorial Hospital & Clinics **BROWARD COUNTY** Broward General • Coral Springs • Florida Medical • Hollywood Medical • Imperial Point • Memorial Hospital Miramar • Memorial Hospital Pembroke • Memorial Regional • Memorial West • North Broward • North Ridge • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center
Hospital/Surgical Requirements: Precertification of hospital confinements	All non-emergency inpatient confinements and physician charges are precertified through the JMH Health Plan.	All non-emergency inpatient confinements and outpatient surgeries are preauthorized through Vista.
Drug & Alcohol Treatment: **Inpatient** **Outpatient**	Covered at 100% up to 30 days inpatient per year. $10 co-payment per visit, limited to 30 outpatient visits per calendar year.	Covered at 100% up to 30 inpatient rehab days per calendar year. Inpatient detox; no co-payment, 7 days per calendar year. $ 10 co-payment up to 60 rehab visits per calendar year.
Mental & Nervous Disorders: **Inpatient** **Outpatient**	Covered at 100% up to 30 days inpatient per year. $10 co-payment per visit, limited to 30 outpatient visits per calendar year.	Covered at 100% up to 30 inpatient days per calendar year. $10 co-payment, up to 30 outpatient visits per calendar year.
Other Services **Ambulance** **Vision**	100% when medically necessary 100% for eye exam per 12 months.** $10 dispensing fee, 100% thereafter for select lenses and frames, for one pair of glasses per member per calendar year. Contact lenses not covered, 20% courtesy discount is available for professional fees and materials.	100% when medically necessary. $15 co-payment for annual eye exam. Vista offers vision services through participating locations listed in our directory. Please refer to your Vista package for a complete list of benefits.

	JMH HEALTH PLAN (HMO) Visit our website at www.jmhhp.com	VISTA HEALTH PLAN (HMO) Visit our website at www.vistahealthplan.com
Prescription Drugs:	$7 Generic***/$20 Brand/$35 Non-Formulary prescription or refill up to 30-day supply including prescription contraceptives, at participating pharmacies. If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment. Mail at Retail Program available. Instead of mailing Rx for a 90-day supply, members may pick-up medication at participating pharmacy with 2X co-payments for a 90-day supply.	$10 Generic/$20 Brand/$30 Non-Formulary for a 30-day supply, at participating pharmacies including prescription contraceptives. Mail order: $20 Generic/$40 Brand for a 90-day supply(Non-Formulary not available thru mail order). If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment.
Durable Medical Equipment (DME):	100% of pre-authorized durable medical equipment, orthotic braces and prosthetics devices, obtained through a JMH Health Plan provider. $25 co-payment per medical condition. Maximum benefit $500 per year.****	Covered at 100%.
Out of Area: **1) Emergency** **2) Non-Emergency**	100% after $50 co-payment (worldwide). Not covered.	$25 co-payment (worldwide), waived if admitted. Not covered.
	* No referrals required for participating specialists office visits ** See plan literature for details regarding vision benefits limitations and exclusions. *** See plan literature regarding purchase of non-Generic drugs. **** See plan literature for benefits and limitations of DME products.	* No referrals required for Specialist Office Visits

METLIFE Dental Plan

	METLIFE	
Choice of Dentist	Program allows you to choose any dentist you wish. Payments to Preferred Dental Providers (PDP) are based on negotiated fees. Payments to non preferred providers are based on Reasonable and Customary (not billed) charges.	
Maximum Benefit/Deductible	$1,000 per year per person $50 deductible per year per person; $150 family maximum	$1,500 per year per person $50 deductible per year per person; $150 family maximum
Type I	**STANDARD** **Plan Pays** (No deductible)	**ENRICHED** **Plan Pays** (No deductible)
0150 Comprehensive Oral Evaluation -New or Established	100%	100%
0120 Periodic Oral Exam	100%	100%
X-rays	100%	100%
1110/20 Prophylaxis	100% (Twice per calendar year)	100% (Twice per calendar year)
1203 Fluoride Treatment (children up to the age 19)	100%, 1x per year	100%, 1x per year
1351 Sealant - per tooth	Not Covered	Not Covered
1510 Space Maintainers	100% to age 19	100% to age 19
Type II	*	*
Fillings: (silver)		
2140 one surface	75% Non PDP/100% PDP	75% Non PDP/100% PDP
2150 two surfaces	75% Non PDP/100% PDP	75% Non PDP/100% PDP
2160 three surfaces	75% Non PDP/100% PDP	75% Non PDP/100% PDP
2161 four or more surfaces	75% Non PDP/100% PDP	75% Non PDP/100% PDP
Root canals:		
3310 Anterior	75%	75%
3320 Bicuspid	75%	75%
3330 Molar	75%	75%
3410 Apicoectomy	75%	75%
Extractions:		
7111 Single tooth	75%	75%
7140 Extraction, erupted tooth or exposed tooth	75%	75%
7210 Surgical extraction of erupted tooth	75%	75%
Periodontics: (gum treatment)		
4341 Periodontal scaling & root planning-per quadrant	75%	75%
4210 Gingivectomy/gingivoplasty - per quadrant	75%	75%
4910 Periodontal maintenance procedures	75%	75%
Type III	*	*
Crown & Bridge		
2930 Prefabricated stainless steel primary tooth	50%	50%
2791 Crown full cast predominately base metal	50%	50%
2751 Crown Porcelain fused to base metal	50%	50%
Pontics:		
6210 Full cast	50%	50%
6240 Porcelain fused to metal	50%	50%
Prosthodontics (Dentures)		
5110 Complete upper	50%	50%
5120 Complete lower	50%	50%
5213/14 Partial upper or lower - cast metal base	50%	50%
ORTHODONTIA		
Consultation	Not Covered	
Evaluation	Not Covered	Adult & Children covered at 50%
Records	Not Covered	after a one time
Children - Normal Class II	Not Covered	deductible of $50 per person.
Adult - Normal Class II	Not Covered	$1,000 lifetime maximum
8750 Retention	Not Covered	
VISION		
Examination	Not Covered	Not Covered
Single Vision Lenses	Not Covered	Not Covered
Bifocal Lenses	Not Covered	Not Covered
Trifocal Lenses	Not Covered	Not Covered
Contact Lenses - Non-Elective	Not Covered	Not Covered
Contact Lenses - Elective	Not Covered	Not Covered
Frames	Not Covered	Not Covered

* All Type II and III charges subject to annual deductible

* The above reimbursements are exclusive of gold.

ADP & OHS Dental Plans

AMERICAN DENTAL PLAN (ADP) Now known as CompBenefits		**ORAL HEALTH SERVICES (OHS)** Now known as CompBenefits	
Limited to Participating Dentists in Private Practice		Limited to Participating Dentists in Private Practice	
No Maximum No Deductible		No Maximum No Deductible	
STANDARD **You Pay*** No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 7.00 35.00	**ENRICHED** **You Pay** No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 7.00 35.00	**STANDARD** **You Pay** No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 6.00 40.00	**ENRICHED** **You Pay** No Charge No Charge No Charge No Charge (Once every 6 months) No Charge No Charge No Charge
No Charge No Charge No Charge No Charge 95.00 135.00 175.00 65.00 No Charge No Charge 20.00 37.50 105.00 UCR Less 25%	No Charge No Charge No Charge No Charge 95.00 135.00 175.00 65.00 No Charge No Charge 20.00 37.50 105.00 35.00	No Charge $11.00 $16.00 $18.00 90.00 155.00 200.00 75.00 No Charge No Charge 15.00 40.00 120.00 25.00	No Charge No Charge No Charge No Charge 45.00 90.00 145.00 65.00 No Charge No Charge No Charge 40.00 90.00 25% Discount
35.00 185.00** 200.00** 185.00** 200.00** 200.00 200.00 250.00	35.00 185.00** 200.00** 185.00** 200.00** 200.00 200.00 250.00	25.00 $210.00 $210.00 25% Discount 25% Discount 230.00 230.00 275.00	No Charge $175.00 $175.00 25% Discount 25% Discount 205.00 205.00 240.00
No Charge UCR Less 25% UCR Less 25% UCR Less 25% UCR Less 25% Additional	No Charge 35.00 250.00 1400.00 1950.00 Additional	25% Discount 25% Discount 25% Discount 25% Discount 25% Discount 25% Discount	No Charge 25.00 200.00 1,400.00 1,950.00 25% Discount
Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	10% Discount 20% Discount 20% Discount 20% Discount 20% Discount 20% Discount 20% Discount

* STD Plan fee apply to participating General Dentist only.

** Co-payments are exclusive of gold.

* Cost of high noble metal additional.

Disability Income Protection Plans

Disability insurance protects one of your most valuable assets: the ability to work. Chances are that you do not have enough money in your personal or other long-term savings accounts that would allow you to miss more than two months of work without suffering financial consequences.

The following Disability Income Protection Insurance plans can provide you with a weekly (STD) benefit or monthly (LTD) benefit if you become disabled, as defined in the policy. Choose short term or long term disability income protection insurance, or both. An employee must be actively at work for coverage to begin. Minimum requirement for active employment is 60 hours bi-weekly.

For employees who previously chose not to participate in this plan, Evidence of Insurability (EOI) will not be required during the 2007 open enrollment. Short-Term and Long-Term Disability insurance that requires medical evidence of insurability will not become effective until your EOI application is approved by MetLife and you are actively at work. To receive an EOI form, please see your DPR or download from the online menu.

Short-Term Disability (STD) Income Protection Highlights

- The Short-Term Disability (STD) Insurance plan may provide up to 60% of your weekly salary, with a maximum benefit of $500 or $1,000 per week.
- Short term disability benefit payments are issued in arrears on a weekly basis, and benefits can continue for each period of disability, but not beyond the maximum benefit period of 26 weeks.
- STD benefits start to accrue after you meet the definition of disability and satisfy a 14-consecutive-day waiting period, or the expiration of all sick leave, whichever is later. Annual leave will automatically be used unless you submit a written request for it not to be paid to you.
- Pregnancy/childbirth is considered a disability just like any other illness or injury that may occur while covered under this plan. For a normal childbirth, disability typically covers you up to a total of six weeks. (Example, if you have two weeks of sick leave, your MetLife benefits would be payable for four weeks.)
- To receive benefits, you must be unable to earn more than 80% of pre disability earnings at your own occupation as a result of sickness or injury.
- No pre-existing limitation clause applies.
- There is no waiver of premium if approved for benefits.

What's Not Covered

Sickness or injuries not covered are those resulting from:

- War or acts of war, declared or undeclared, insurrection, rebellion, or terrorist act.
- Active participation in a riot.
- Committing or attempting to commit a felony or assault.
- Work related injury or sickness.
- Intentionally self-inflicted injuries.
- Attempted Suicide.

Long-Term Disability (LTD) Income Protection Highlights

- The Long-Term Disability (LTD) Insurance plan can provide up to 60% of your monthly salary, with a maximum benefit of $2,000 or $4,000 per month.
- Benefits can continue for each period of total disability according to the schedule below.
- The minimum monthly benefit is the greater of $100, or 10 percent of the gross monthly benefit before deductions for other income benefits.

LTD benefits start to accrue after you meet the definition of disability as defined in the policy and satisfy the waiting period of 180 days. Before LTD benefits will begin, an employee must exhaust any short-term disability or the expiration of all sick leave, whichever occurs later. Annual leave will automatically be used unless you submit a written request for it not to be paid to you.

- As long as you are receiving disability benefits from MetLife, your monthly premiums are waived.

Age at time of Disability:	LTD Benefits payable for following maximum:
Under 60	To age 65, but no less than 60 months
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

Long-Term Definition of Disability:

You are disabled when MetLife determines that:

1. Due to Sickness, or as a direct result of accidental injury, you are receiving appropriate care and treatment and complying with the requirements of such treatment; and
2. You are unable to earn more than 80% of your predisability earnings at your own occupation for any employer in your local economy.

Disability Income Protection Plans

Long-Term Disability Income Protection (cont.)

After 24 months of payments, you are disabled when MetLife determines that:

1. Due to Sickness, or as a direct result of accidental injury, you are receiving appropriate care and treatment and complying with the requirements of such treatment; and
2. You are unable to earn more than 80% of your predisability earnings from any employer in your local economy at any gainful occupation for which they are reasonably qualified taking into account their training, prior education and experience.

Rehabilitation and Return to Work Assistance:
Vocational rehabilitation experts provide qualified employees with formalized assessment and planning as well as financial support to help them return to productive, independent lifestyles.

What's Not Covered

Sickness or injuries not covered are those resulting from:

- War or acts of war, declared or undeclared, insurrection, rebellion, or terrorist act.
- Active participation in a riot
- Committing or attempting to commit an assault or felony
- Work related injury or sickness
- Intentionally self-inflicted injuries.
- Attempted Suicide.

Annual Leave and Your Disability Benefits

If you are on sick leave and your sick leave runs out, the County automatically uses any accrued annual leave. However, if you purchase short-term or long-term disability insurance, you can choose not to be paid for your annual leave even if you exhaust your sick leave. Contact your Departmental Personnel Representative and **request in writing** that your annual leave not be paid to you during your absence from work due to illness or injury.

What if I receive benefits from another group disability plan, Social Security or the Florida Retirement System?

Both the short-term and long-term disability plans coordinate with benefits payable under any statutory disability law, the Federal Social Security Act and any other federal, state, county or municipal retirement acts or laws. These benefits also coordinate with any other group policies you may have that provide disability benefits. Any employer-sponsored salary continuation or retirement program benefits are coordinated as well.

Coordination of disability benefits means the disability payments you receive are offset by the amount you receive from other sources of income as defined in the policy.

Termination of Coverage

Your coverage under the policy ends on the earliest of the following:

- the date the policy or plan is cancelled
- the date you no longer are in an eligible group
- the date your eligible group is no longer covered
- the last day of the period for which you made any required contributions or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

MetLife will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

Delayed Effective Date

This insurance coverage will be delayed if you are not in active employment because of injury, sickness, temporary layoff or leave of absence on the date that this insurance would otherwise become effective. This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to the Policy.

Policy Provider

Metropolitan Life Insurance Company underwrites these plans.

Biweekly premiums
Short Term (Low Option and High Option plans):
$1.54 per $100 of Weekly Benefit
Long Term (Low Option plan): $0.26 per $100 of Covered Payroll
Long Term (High Option plan): $0.31 per $100 of Covered Payroll

Disability Calculator

STD Low Option:
Biweekly Premium = Adj. Biweekly Salary (capped at $1,666.67) ÷ 2 x 0.60 x 0.0154

STD High Option:
Biweekly Premium =Adj. Biweekly Salary (capped at $3,333.34)) ÷2 x 0.60 x 0.0154

LTD Low Option:
Biweekly Premium = Adj. Biweekly Salary (capped at $1,538.76) x 26 ÷12 x 0.0026

LTD High Option:
Biweekly Premium = Adj. Biweekly Salary (capped at $3,077.52) x 26 ÷12 x 0.0031

Online Calculator
available effective January 1, 2007
http://www.miamidade.gov/benefits and check on left navigation link for Calculator.

Disability Income Protection Plans

Questions and Answers

Q1. Is the STD and LTD disability provider changing effective January 1, 2007?

A1. Yes. Metlife Insurance Company will replace Unum as the disability provider.

Q2. What are the main differences in plan design between the new Metlife disability plan and the disability plans offered by Unum?

A2. The plan design has been enhanced for 2007 to give employees more choices in selecting the level of protection more suitable for their needs. The STD and LTD plans both offer Low and High Option benefit levels. Employees may choose one of two options offered for STD and/or one of two options offered for LTD. Biweekly employee premium deductions will be post-tax and based on the employee's salary and option selected rather than age as offered under Unum. Since premiums will be post-tax, any disability benefit payments received will be tax free.

Q3. What is a pre-existing condition?

A3. A pre-existing condition means a sickness or accidental injury for which the employee:

- Received medical treatment, consultation, care or services;
- Took prescription medication or had medications prescribed; or
- Had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment;

In the three months before the employee's insurance or any increase in the amount of such insurance takes effect.

Metlife will not pay benefits, or any increase in benefits, to an employee who elects to increase the amount of the insurance for a disability resulting from a pre-existing condition, if the employee has been actively at work for less than 12 consecutive months after the date the employee's disability insurance or the elected increase in the amount takes effect.

Q4. Does the new Metlife disability plan include pre-existing condition rules for employees currently enrolled under the Unum Long-Term disability plan?

A4. Metlife has special pre-existing rules for employees enrolled for the Unum LTD Plan as of December 31, 2006. In determining whether a disability is due to a pre-existing condition, Metlife will credit you for any time you were insured under Unum. If the disability is due to a pre-existing condition, but would not be due to a pre-existing condition under the Unum plan, Metlife will pay a benefit for the lesser of:

- The benefit amount under the Metlife certificate or
- The disability income insurance benefit that would have been payable to you under Unum.

If the disability would have been due to a pre-existing condition under Unum, it will be treated as having been caused by a pre-existing condition under Metlife.

Q5. Does the new Metlife disability plan include pre-existing condition rules for the Short-Term disability plan options?

A5. No.

Q6. If I am currently enrolled for Unum STD and/or LTD, am I required to submit evidence of insurability (EOI) to Metlife?

A6. No.

Q7. What is guaranteed issue?

A7. Guaranteed issue means all eligible employees not enrolled for STD and/or LTD coverage as of December 31, 2006 are eligible to enroll for Metlife disability coverage without submitting evidence of insurability. Coverage will become effective January 1, 2007 providing the employee is actively at work.

Q8. If I am not currently enrolled for Unum STD or LTD coverage, am I required to complete evidence of insurability Metlife?

A8. No. Metlife will not require evidence of insurability to enroll in the disability program during the 2007 open enrollment period.

Q9. If I am currently disabled and receiving a weekly STD benefit or a monthly LTD benefit, will there be any disruption in my benefits if I am deemed disabled beyond December 31, 2006?

A9. No. Unum will continue to be responsible for paying your weekly or monthly benefit until the earlier of a) exhausting the benefit or b) no longer meeting the criteria to receive disability benefits.

Q10. I am currently enrolled for STD and/or LTD coverage with Unum and wish to continue coverage for 2007. What happens if I do not go online to submit a change?

A10. If you do not submit an online change to Metlife, your benefit will be defaulted to the lower of the STD and/or LTD options offered by Metlife and the appropriate premium contributions will be payroll deducted effective January 1, 2007. For example, if currently enrolled for Unum's STD and you do not submit a change online, your coverage will be defaulted to the $500 maximum benefit per week Metlife STD plan.

Flexible Spending Accounts

What is a Flexible Spending Account (FSA)?

Fringe Benefits Management Company (FBMC) provides you with IRS tax-favored FSAs to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:
- IRS-approved reimbursement of eligible expenses tax free
- per-pay-period deposits from your pre-tax salary and
- savings on income and Social Security taxes.

Is an FSA right for me?

If you spend $260 or more on recurring eligible expenses during your plan year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.
- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis at **www.myFBMC.com/customer/taxanalysis.asp**.

What types of FSAs are available?

Your employer offers you a Healthcare FSA as well as a Dependent Care FSA. If you incur both types of expenses during a plan year, you can establish both types of FSAs.

Healthcare FSAs

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Healthcare FSA, including:
- birth control pills
- eyeglasses
- orthodontia and
- Over-the-Counter items. (see FBMC's Web site for quarterly updates)

Dependent Care FSAs

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:
- day care services
- in-home care
- nursery and preschool and
- summer day camps.

Refer to the Healthcare FSA and Dependent Care FSA sections of this Reference Guide for specifics on each type of FSA.

Receiving Reimbursement

Your reimbursement will be processed within five business days from the time FBMC receives your properly completed and signed FSA Reimbursement Request Form. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.
- FSA reimbursement funds are automatically deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed).

To apply, complete the Direct Deposit Enrollment Form available from FBMC's website at **www.myFBMC.com** or call FBMC Customer Service at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four to six weeks.

Where can I get information about FSAs?

If you have specific questions about FSAs, contact FBMC Customer Service.
- Visit www.myFBMC.com.
- Call 1-800-342-8017 (Monday-Friday, 7 a.m.-10 p.m. ET).

Please note that due to FBMC's Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.

FSA Savings Example*

$31,000	Annual Gross Income	$31,000
- 5,000	FSA Deposit for Recurring Expenses	- 0
$26,000	Taxable Gross Income	$31,000
- 5,889	Federal, Social Security Taxes	-7,021
$20,111	Annual Net Income	$23,979
- 0	Cost of Recurring Expenses	-5,000
$20,111	Spendable Income	$18,979

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

$1,132!

*Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year

Flexible Spending Accounts

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA. Refer to the "Written Certification" portion of the Beyond Your Benefits section of this Benefits Handbook for more specifics.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Healthcare FSA or vice versa.
3. You have a grace period of two months and 15 days following the end of your 2007 Plan Year (December 31, 2007) for a Healthcare FSA. This new grace period ends on March 15, 2008. During the grace period, you may incur expenses and submit claims for these expenses. Funds will be automatically deducted from any remaining dollars in your 2006 Healthcare FSA balance.
4. You have a 120-day run-out period (until April 30, 2008) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage within the 2007 Plan Year and grace period.
5. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
6. You cannot deduct reimbursed expenses for income tax purposes.
7. You may not be reimbursed for a service that you have not yet received.
8. Be conservative when estimating your medical and/or dependent care expenses for the 2007 Plan Year. IRS regulations state that any unused funds which remain in your FSA after a plan year and grace period ends (and all reimbursable requests have been submitted and processed) cannot be returned to you nor carried forward to the next plan year.

Termination or Leave:

If you terminate employment or go on unpaid leave, your eligibility for either or both FSAs may change.

Healthcare FSAs

If you experience an event permitting a mid-plan year FSA election change such as termination of employment or unpaid leave, you can continue to contribute to your Healthcare FSA on an after-tax basis by calling FBMC Customer Service at 1-800-342-8017 within **45 days** (60 days for newborns) of the event.

As long as you make full after-tax contributions to your Healthcare FSA, you can receive reimbursements on eligible healthcare expenses incurred during your period of coverage.

You have a 120-day run-out period (until April 30, 2008) after the plan year ends to submit claims for reimbursement of eligible FSA expenses which you incurred during your period of coverage. Your Healthcare FSA coverage will not be continued beyond the plan year in which the COBRA-qualifying event occurred.

Specific guidelines about termination and leave policies can be obtained from your DPR. In addition, the Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact your DPR for further information and to obtain any paperwork necessary to complete.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage when on leave. Please contact your DPR for further information.

Dependent Care FSAs

You cannot continue contributing to your Dependent Care FSA. You can, however, continue to request reimbursement for eligible expenses incurred while employed until you exhaust your account balance or the plan year ends.

What documentation of expenses do I need to keep?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year.

How do I get the forms I need?

To obtain forms you will need after enrolling in either a Healthcare or Dependent Care FSA, such as an FSA Reimbursement Request Form, Letter of Medical Need or Direct Deposit Form, you can visit FBMC's Web site, **www.myFBMC.com,** or call FBMC Customer Service at 1-800-342-8017. For more information, refer to the Getting Answers section of this Benefits Handbook .

Will contributions affect my income taxes?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting an FSA. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

Healthcare FSA

Healthcare FSA
Minimum Annual Deposit:
$260 per year ($10 per pay period)
Maximum Annual Deposit: $5,000
(including a $50.96 annual administrative fee)

What is a Healthcare FSA?

A Healthcare FSA is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found in this section.

Whose expenses are eligible?

Your Healthcare FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

An individual is a qualifying child if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 18 years old or younger (23 years, if a full-time student) at the end of the taxable year and
- have not provided more than one-half of their own support during the taxable year (and receive more than one-half of their support from you during the taxable year if a full-time student age 19 through 23 at the end of the taxable year).

An individual is a qualifying relative if they are a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- have a specified family-type relationship to you, are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year or
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Healthcare FSA.

When are my funds available?

Once you sign up for a Healthcare FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of the plan year.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Healthcare FSA reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires the complete name of all medicines and drugs be obtained and documented on pharmacy receipts (including prescription name, date(s) of service, and total dollar amount). This information must be included when submitting your request to FBMC for reimbursement.

Can travel expenses for medical care be reimbursed?

Travel expenses primarily for, and essential to, receiving medical care, including health care provider and pharmacy visits, may be reimbursable through your Healthcare FSA. With proper substantiation, eligible expenses can include:

- actual round-trip mileage
- parking fees
- tolls and
- transportation to another city.

Is orthodontic treatment reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable if the proper documentation is attached to the initial FSA Reimbursement Request Form each plan year:

- a written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service and the cost for the service and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment.

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call FBMC Customer Service at 1-800-342-8017.

Should I claim my expenses on IRS Form 1040?

With a Healthcare FSA, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax free, regardless of the amount. By enrolling in a Healthcare FSA, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on their percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Healthcare FSA Directory

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Healthcare FSA include:

- insurance premiums
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

Complete information on ineligible expense can be found in IRS Publication 502 at www.irs.gov.

When do I request reimbursement?

You may use your Healthcare FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

How do I request reimbursement?

Requesting reimbursement from your Healthcare FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with the following:

- a receipt, invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided and
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost or
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the receipt, invoice or bill for the service.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Visit www.myFBMC.com for a list of frequently asked questions.

You must keep your receipts for a minimum of one year and submit to FBMC upon request.

**EOBs are not required if your coverage is through a HMO.*

Partial List of Medically Necessary Eligible Expenses*

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
Injections and vaccinations
In vitro fertilization
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

***Note:** Budget conservatively. No reimbursement or refund of Healthcare FSA funds is available for services that do not occur within your plan year or grace period.*
**IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.*

OTC Category Reimbursement

Over-the-Counter Expenses

Your Over-the-Counter (OTC) items, medicines and drugs may be reimbursable through your Healthcare FSA! Save valuable tax dollars on certain categories of OTC items, medicines and drugs. You may be reimbursed for OTCs through your Healthcare FSA if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by your employer's Healthcare FSA plan and IRS regulations and
- you submit your reimbursement request in a timely and complete manner already described in your benefits enrollment information.

Note: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at **www.myFBMC.com**. As soon as an OTC item, medicine or drug becomes eligible under any of the categories below, it will be reimbursable retroactively to the start of the current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Healthcare FSA election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Eligible Expense Categories

Allergy
Antihistamines
Nasal sprays

Antacids
Heartburn medicines

Cold Remedies
Cough drops
Decongestants
Nasal strips
Nasal sprays
Sinus medications
Throat lozenges

Pain Relief
Bug bite medication
Fever reducers
First aid creams (diaper, fever blister, poison ivy)
Menstrual cycle products for pain and cramp relief
Products for muscle or joint pain
Special ointments or creams for sunburn
Topical creams

Other Medical Remedy Items
Anti-diarrheals
Anti-fungals
Antibiotics
Asthma medications
Bandages, gauze pads, rubbing alcohol, liquid adhesives
Carpal tunnel wrist supports
Cold/hot packs for injuries
Corn/callus removers
Eye products (including reading glasses, contact lens cleaning solutions)
First aid kits
Hemorrhoid treatments
Laxatives
Motion sickness treatments
Nicotine gum or patches for smoking cessation purposes
Thermometers
Wart removers

Items Requiring Special Documentation*

Botanicals/herbals
Feminine hygiene products
Hormones
Minerals
Nasal sprays for snoring
Sunscreens
Vitamins
Weight-loss drugs to treat a specific disease

Ineligible OTC Expenses

Cosmetics
Toiletries
OTC items primarily for general health and well-being

* Contact FBMC Customer Service at www.myFBMC.com or call FBMC Customer Service at 1-800-342-8017 for more information or to obtain a sample Letter of Medical Need or Personal Use/Capital Expenditures Statement.

Dependent Care FSA

Minimum Annual Deposit:
$260 per year ($10 per pay period)
Maximum Annual Deposit: The maximum contribution depends on your tax filing status as the list below indicates.
(including a $50.96 annual administrative fee)

Partial List of Eligible Expenses*

After school care
Baby-sitting fees
Day care services
In-home care/au pair services
Nursery and preschool
Summer day camps

Note: Budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

What is a Dependent Care FSA?

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

You may use your Dependent Care FSA to receive reimbursement for eligible dependent care expenses for qualifying individuals.
A qualifying individual includes a qualifying child, if they:
- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 12 years old or younger and
- have not provided more than one-half of their own support during the taxable year.

A qualifying individual includes your spouse, if they:
- are physically and/or mentally incapable of self care
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home.

A qualifying individual includes your qualifying relative, if they:
- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- are physically and/or mentally incapable of self care
- are not someone else's qualifying child
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home
- receive more than one-half of their support from you during the taxable year.

Note: If you are the tax dependent of another person, you cannot claim qualifying individuals for yourself. You cannot claim a qualifying individual if they file a joint tax return with their spouse. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

What is my maximum annual deposit?

- If you are married and filing separately, your maximum annual deposit is $2,500.
- If you are single and head of household, your maximum annual deposit is $5,000.
- If you are married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

When are my funds available?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Healthcare FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care FSA is always tax free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA cannot be filed for the dependent care tax credit, and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information. You may also visit **www.myFBMC.com** to complete a Tax Savings Analysis.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Dependent Care FSA include:
- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

Dependent Care FSA

Will I need to keep any additional documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must compose a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS Form 2441.

When do I request reimbursement?

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

How do I request reimbursement?

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with documentation showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

Mail to:

Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

FSA Worksheets

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

HEALTHCARE FSA WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Coinsurance or co-payments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses	$ _____

TOTAL
Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed $4,949.04. $ _____

DIVIDE by the number of paychecks you will receive during the plan year (26).* $ _____

This is your pay period contribution. $ _____
Remember to review your first paycheck to be certain the correct amount has been reduced from your salary ($190.34 maximum per pay period).

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

DEPENDENT CARE FSA WORKSHEET

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Day care services	$ _____
In-home care/au pair services	$ _____
Nursery and preschool	$ _____
After school care	$ _____
Summer day camps	$ _____

ELDER CARE SERVICES

Day care center	$ _____
In-home care	$ _____

TOTAL
Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed $4,949.04. $ _____

DIVIDE by the number of paychecks you will receive during the plan year (26).* $ _____

This is your pay period contribution. $ _____
Remember to review your first paycheck to be certain the correct amount has been reduced from your salary ($190.34 maximum per pay period).

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Your annual FSA administrative fee is $50.96, regardless of which type of account you select. However, even if you select both accounts, your total fee will not exceed $50.96.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit.

Changing Your Coverage

Am I permitted to make mid-plan year election changes?

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-plan year election change to your benefit elections, or vary a salary reduction amount, depending on the qualifying event and requested change.

How do I make a change to my health plan mid year?

You may add or delete dependents to your health plan during the plan year only under limited circumstances as provided under your employer's plan document and IRS guidelines. A partial list of permitted changes appear on the following page. Election changes must be consistent with the event. Mid-year changes from one health plan to another, are not permitted.

How do I make an FSA change?

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances as provided by your employer's plan(s) and established IRS guidelines. A partial lists of permitted qualifying events under your employer's plan(s) appear on the following page. Election changes must be consistent with the event. For example: if you get divorced, an IRS special consistency rule allows you to lower or cancel your Healthcare FSA coverage for the individual involved. The Benefits Administration Unit of Risk Management, General Administration Unit will review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To Make a Change: Within 45 days (60 days to add newborns) of an event that is consistent with one of the events on the following page, you must complete and submit a Flexible Benefits Change in Status Form and Health Plan Status Change Forms to your Department Personnel Office. Contact your DPR or the Benefits Administration Unit to obtain these forms. Documentation supporting your election change request is required. You do not need to delay submission of your Change in Status and Health Plan Status Change Forms while you gather your documentation. Simply forward the forms to your DPR and present your documentation as soon as it becomes available.

Upon the approval and completion of processing your election change request, your existing elections will be stopped or modified (as appropriate). Generally, mid-plan year, pre-tax election changes can only be made prospectively, no earlier than the first payroll after your election change request has been received by the Benefits Administration Unit, unless otherwise provided by law.

What is my FSA Period of Coverage?

Your period of coverage for FSAs is your full plan year, unless you make a permitted mid-plan year election change. A mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

What are the IRS Special Consistency Rules governing Changes in Status?

1. **Loss of Dependent Eligibility-** If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. **Gain of Coverage Eligibility Under Another Employer's Plan-** If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
3. **Dependent Care Expenses-** You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.

Appeals Process for Denied Change in Status Requests

If you have a request for a Change in Status denied, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to the Benefits Administration Unit of Risk Management, GSA. Your appeal must include:

- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied and
- any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed by an independent committee comprised of management level County employees. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

Changing Your Coverage

Mid-Year Permitted Changes in Status:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.
Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within **45 days** (60 days to add newborns) of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.
Unpaid Leave of Absence	You may submit a completed Flexible Benefits Change in Status Form and Insurance Status Change form within **45 days** of being in a leave without pay status to temporarily cancel your health insurance coverage. Upon return to pay status (within **45 days**), you must re-submit a completed Flexible Benefits Change in Status form and Insurance Status Change Form to your DPR to reinstate coverage.

* Does not apply to a Medical Expense FSA plan.
† Does not apply to a Dependent Care FSA plan.

ARAG® Legal Services

How many times have you wished you had an attorney to consult regarding wills, real estate, court proceedings or other legal issues? With the Group Legal Services plan, you have the professional legal help you need to protect yourself and your loved ones from legal difficulties.

Are my premiums tax-free?

No. Your premiums will be deducted from your paycheck after taxes have been calculated.

Eligible Expenses

Coverage

Telephone Legal Advice and Consultaton
You can consult with a Telephone Network Attorney over the phone as often as necessary for the following issues:
• Legal advice and consultation
• Standard will preparation
• Living will preparation
• Durable powers of attorney preparation
• Small claims assistance
• Follow-up calls and letters
• Specific document preparation
• Document review; up to four pages

Financial and Tax Planning Services
Personal Financial Counseling
The telephone financial counseling service includes toll-free confidential telephone access to an experienced financial planner, planning information, analysis tools and resources that cover a broad range of financial and consumer needs, such as buying vs. leasing a car, budgeting tips, selecting a checking account, managing credit card debt, etc.
Interactive Financial Web Site
Via your Legal Benefits Web Site at http://members.ARAGgroup.com/MDCounty, you have access to an interactive financial Web site that incudes calculators, a library of content, planning resources and much more.

Online Legal Tools and Resources
Some legal issues can be solved quickly with the right information. With your plan, it can be as simple as going online to find everything you need. The Law Guide is a legal encyclopedia of thousands of easy-to-read legal articles to help you research and learn more about your legal situation. Do-It-Yourself Legal Documents™ is an online legal library that has hundreds of documents, if you want the convenience and control of preparing some straightforward legal documents yourself. These services are included in the price of the plan and are available to you by logging into your Legal Benefits Web Site at http://members.ARAGgroup.com/MDCounty.

Identity Theft Services
Identity theft occurs when someone obtains personal information (credit card number, Social Security Number, account number, etc.) and uses it without your knowledge to commit fraud or theft. ARAG recognizes that you need help with this increasingly popular crime. Now, you can call ARAG toll-free and speak with an Identity Theft Case Manager who will:
• Explain what identity theft is and how to prevent it.
• Provide resources to minimize and recover from identity theft.
• Explain relevant plan coverages
• Provide an identity theft prevention kit and/or an identity theft victim action kit.
• Monitor and follow up on the situation.

Immigration Assistance
Your legal plan also includes access to an Immigration Case Manager who will assess your situation and determine appropriate steps to meet your need. You will also receive toll-free telephone advice from an attorney on how immigration law relates to your legal matter and what actions may be taken. Plus, if you need to speak to an attorney about your matter, reduced rate services are available for immigration matters that can't be handled over the phone. If a plan member needs to see a state-specific immigration Attorney, our local Network Attorneys will offer up to a 25 percent reduced rate off their normal fees/rates for any review, preparation or representation-based Network services are covered under the plan.

ARAG® Legal Services

In-Office Legal Representation

Coverage	Network Attorney	Non-Network Attorney* Amount Reimbursed
Consumer Protection	Paid in full	$2,200**
Representation in a legal action required for the enforcement of written or implied warranties or promises relative to the lease or purchase of goods or services (except structural damage) is available. Actual amount in dispute must be at least $500.		
Consumer Debt Collection Defense	Paid in full	$2,200**
Defense of lawsuit based upon a contract or written instrument is available.		
Adoption Proceedings	Paid in full	$300*
Uncontested Guardianship/Conservatorship	Paid in full	$300*
Incompetency or Infirmity Proceedings	Paid in full	$2,200**
Name Change	Paid in full	$240
Juvenile Court Proceedings Involving an Insured Child	Paid in full	$2,080**
Service does not include proceedings involving traffic matters.		
Habeas Corpus Court Proceedings	Paid in full	$300
(including Powers of Attorney and Ordinary Trust Provisions)		
Estate Planning (Wills)		
Individual Simple Will	Paid in full	$100
Husband and Wife Simple Wills (including Powers of Attorney and Ordinary Trust Provisions)	Paid in full	$125
Codicil	Paid in full	$60
Wills with other than Ordinary Trust Provisions	Paid in full (up to 6 hours)	$300*
Living Will	Paid in full	$60
Durable Power of Attorney	Paid in full	$60
IRS Audit Protection		
Legal services involving personal tax IRS audits for which you receive written notice while your certificate of insurance is in effect and which relate to your personal federal tax return.		
Advice consultation and negotiation	$420*	$420*
Representation at IRS audit	$900*	$900*
IRS Collection Defense		
Legal defense against collection actions by the Internal Revenue Service regarding a members personal federal tax return is available. The member must receive written notice while his/her Certificate of Insurance is in effect.		
Legal Services and court representation prior to trial	$1,800*	$1,800*
Court representation at trial as a defendant	$1,600**	$1,600**
Estate Administration and Estate Closing		
Legal assistance is provided to you in administering an insured's bequest which you inherit while your Certificate of Insurance is in effect.		
Advice, negotiations and office work and/or the applicable property transfers and court appearances	$500*	$500*
Administrative Hearings	Paid in full	$1,200*
The services cannot be related to insured's employment, but includes advice and document preparation related to an Insured's Immigration Proceedings.		
Major Trial	Paid in full	$5,000***
Preventive Legal Services	Paid in full	$360*
Six hours each plan year per family for office advice, negotiation and document preparation and review (e.g., leases, promissory notes, demand letters, affidavits, deeds and mortgages)		
Real Estate Matters	Paid in full	Sale $360*
Representation of insured in the sale or purchase of a principal residence (benefit limited to one sale or one purchase per plan year)		Purchase $240*

ARAG® Legal Services

In-Office Legal Representation (cont.)

Coverage	Network Attorney	Non-Network Attorney* Amount Reimbursed
The following benefits are effective only after a six-month waiting period.		
Personal Bankruptcy	Paid in full	$420*
Dissolution of Marriage (employee only)		
Divorce, legal separation or annulment		
Uncontested or Contested	Paid in full	$420
or	Paid in full (up to 20 hours per event)	$1,080*
Defense of a motion to modify a divorce decree	Paid in full	$360*

In-office legal representation is limited to one usage per family per plan year.

* Non-network Attorney coverage is $60 per hour up to the stated amount.

** Trial Indemnity benefits of $1,600 for up to three days of trial time are included in this amount ($200 per ½ day of trial time).

*** Major Trial time is paid at the rate of $200 per ½ day of trial time.

ARAGdirect.com (Non-Plan Member)

LegalRx is a plan designed to provide legal information and affordable attorney access when an employee faces an unexpected legal situation but chose not to enroll in the comprehensive insurance plan. You can access LegalRx through ARAGdirect.com by visiting the FAQ page at your Legal Benefits Web Site at: http://members.ARAGgroup.com/MDCounty.

What's Not Covered?

- Actions or disputes between you and your employer, or your employer's insurance carrier, unions, plan underwriter and any party when coverage is prohibited by law
- Workers' Compensation, Unemployment Compensation, Class Actions, Interventions and Amicus Curiae
- Matters relating to patents, copyrights or appeal proceedings
- Duplication of services previously claimed in relation to same matter
- Probating of estates, title insurance, title search, title abstracting, filing fees, reporter's fees and court costs
- Services regarding matters resulting from your occupation, including business interests, transactions, pursuits and partnerships
- Any legal matter which occurs or is initiated prior to your effective date of coverage (This includes the dates for which an infraction occurs, a document is filed with the court or an attorney is hired.)
- Preparing, completing, or filing of a federal, state, or local tax return
- Contingency fee cases and similar matters for which a fee is normally allowed by law
- Any action brought in Small Claims Court
- Any legal proceeding in which you are entitled to legal representation or reimbursement for the costs thereof from any source other than this policy or another legal expense policy
- Matters related to structural damage to dwellings, appurtenances and paved surfaces

If you are unsure whether a matter is covered, contact ARAG at 800-247-4184 and a Customer Care Counselor will provide you information on limitations and exclusions.

Who are my eligible dependents?

- Your spouse (unless also an eligible County employee).
- All unmarried dependent children to the end of the calendar year turning 19. Coverage may be extended to the end of the calendar year turning 25 if the unmarried dependent child is a full-time or part time student or residing in the employee's household.

Important Note

If you elect coverage for yourself and one dependent, the first dependent for whom you file a claim will be considered the only dependent covered under this plan

Plan Provider

ARAG is a leading administrator of legal advisory plans and ARAG Insurance Company is rated A (Excellent) by A.M. Best Company.

Insurance products are underwritten by ARAG® Insurance Company of Des Moines, Iowa or GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Of West Des Moines Iowa. Service products are provided by ARAG LLC, ARAG Services LLC, or Advisory Communication Systems Inc.depending on the product and state. Some products are only available through membership in the ARAG Association LC.

This material is for illustrative purposes only and is not a contract. For terms, benefits and exclusions, call our toll free numbers.

Your After-tax Rates

Level of Coverage	Biweekly Premium
Employee Only	$ 7.37
Employee & One Dependent	$ 9.45
Employee & Family	$ 9.72

To locate Participating Attorneys

You may visit your Legal Benefits Web Site at: **http://members.ARAGgroup.com/MDCounty** to view a list of Network Attorneys and plan benefits or contact ARAG at (800)247-4184.

Deferred Compensation Plan

When you retire, you'll want to maintain the lifestyle you currently have. Social Security and the Florida Retirement System are not intended to replace all of your income at retirement. It is wise to start a savings plan now. The Deferred Compensation Plan is a tax-deferred savings plan that can be used at retirement to supplement your Florida Retirement System and Social Security benefits.

Eligibility

All Miami-Dade County employees are eligible to participate in this plan. There is no waiting period or minimum number of hours you must work biweekly.

Plan Features

- Contributions are made to your deferred compensation account through payroll deductions.
- Contributions are taken from your gross salary before Federal Withholding taxes are calculated.
- Your contributions are invested in the products of your choice.
- You don't pay Federal Withholding Income taxes on your investment contributions or earnings until you receive the money.
- Social Security taxes on contribution amounts continue to be deducted from your gross salary.
- This plan is governed by Section 457 Internal Revenue Code.

What happens to the money I contribute?

You choose between two providers, International City Management Association Retirement Corporation (ICMA-RC) or National Association of Counties (NACo), administered by Nationwide Retirement Solutions (NRS). You may contribute to both providers if you wish, as long as you do not exceed the total maximum annual contribution.

Each provider offers a number of investment options, including fixed funds, stock funds, bond funds, mutual funds and others. You may wish to seek the advice of an accountant or other professional for investment assistance.

Both ICMA-RC and NRS have representatives available to meet with plan participants one-on-one to discuss your financial objectives. Contact your DPR for the name and telephone number of the plan representative(s) assigned to your department. In addition, onsite representatives are available in the Benefits Administration Unit. Please see page 2 of this Handbook for times and contact information.

Payouts

- Once you retire or separate employment, you become eligible for payments from your account. There is neither a minimum age requirement nor a waiting period for you to begin receiving payments.
- You are not required to select a payout commencement date. At the time you are ready to begin receiving your payout, simply contact your plan provider.
- Once you are eligible to receive payments, you may select from a variety of payment options. You may receive a lump sum, installment payments, irregular payments or guaranteed monthly payments for life.
- You may rollover funds from another eligible retirement plan, your FRS DROP account, or IRA into the 457 plan. You may also rollover your 457 funds into another eligible retirement plan or to an IRA.

"Catch-up" Provision

If you are within three years prior to the year you designate for normal retirement, you may be eligible to take advantage of a special "catch-up" provision which may allow you to contribute up to $30,000 for 2007. You may not participate in the "catch-up provision" beyond age 70½. Additionally, there is an age 50 "catch-up" provision that permits an employee to contribute an extra $5,000 per year, if at least age 50. You may not utilize both "catch-up" provisions simultaneously. Contact the Benefits Administration Unit at 305-375-5633 or 305-375-4288 or the on site plan representative for more information.

Unforeseeable Emergency Withdrawal

You may be able to withdraw money from your account while you are still working if you have an unforeseeable emergency. An unforeseeable emergency is a severe financial hardship to the participant resulting from a sudden and unexpected illness or accident of the participant or of a dependent of the participant, loss of the participant's property due to casualty or other similar extraordinary circumstances arising as a result of events beyond the control of the participant. The amount of money you could receive is limited to the amount necessary to relieve the hardship.

An Unforeseeable Emergency withdrawal is very difficult to receive, and you should not depend on the availability of your funds. Some examples of an Unforeseeable Emergency are health care and property losses due to theft or fire, which are not covered by insurance.

Employees can contact their provider directly to request an emergency withdrawal packet.

Loan Provision

The 457 deferred compensation plans offered through Nationwide Retirement Solutions and ICMA-RC allow participants to borrow up to 50% of their plan balance, not to exceed $50,000, for the purchase of a primary residence only. For employees participating in both plans, the $50,000 limit is the combined maximum. For additional information, please contact the plans directly visit their websites or contact the onsite plan representatives.

2007 Biweekly Minimum Contribution: $10 per pay period
2007 Annual Maximum Contribution: 100% of your gross taxable salary or $15,000 (whichever is less)

Group Term Life Insurance

If you are like most people, you want to make sure that your loved ones are adequately provided for should something happen to you.

Basic Life

The County provides you with group term life insurance equal to your annual adjusted base salary.

Plan Features

- Benefits are payable for death from any cause to the beneficiaries you name.
- Beneficiary designations may be updated at any time.
- If death results from accidental injuries, your beneficiary may be eligible to receive Group Accidental Death and Dismemberment Insurance (AD&D) equal to your annual base salary.
- Dismemberment benefits, up to the same amount as your group term basic life coverage, are payable for loss of hand, foot or sight of eye resulting from an accident. See your policy for plan provisions.
- Employee must be actively at work for coverage to start.

How to enroll for basic life coverage

When eligible, you must complete a beneficiary designation form to enroll.

If you don't enroll for this benefit during your initial eligibility period, you may apply during Open Enrollment. However, at that time, coverage is subject to medical approval and may be denied. Contact your Departmental Personnel Representative or the Benefits Administration Unit at 305-375-4288 or 305-375-5633 for the required paperwork. You must be actively at work for coverage to be effective.

DCFF Fire Union-sponsored plan enrollees who change to a County sponsored medical/dental plan during the open enrollment period must complete a MetLife Life Insurance medical statement to be considered for life insurance. Life insurance is subject to medical approval and may be denied. Basic Life Insurance through the DCFF plan will cease as of the open enrollment effective date.

Group Term Optional Life Insurance

Although the County assumes the full cost for your basic life insurance with MetLife, you may purchase additional life insurance called, "Optional Life Insurance." Employees applying within their eligibility period, or 30 day grace period, may enroll for up to three times annual adjusted salary without evidence of insurability. All other amounts are subject to evidence of insurability.

Plan Features

- If interested, you should elect coverage at the time you sign up for group medical, dental, vision and/or basic life benefits.
- You may apply for coverage up to five times your annual adjusted base salary.
- Premiums are age-based and depend on the amount of coverage purchased. Contact your Departmental Personnel Representative or the Benefits Administration Unit at 305-375-5633 or 305-375-4288 for further details. Visit the online premium calculator at http://www.miamidade.gov/benefits and check on left navigation link for Calculator.
- You may reduce the level of coverage or cancel coverage at any time. However, if you wish to re-enroll for coverage or increase the coverage level, you must submit an application during the annual optional life Open Enrollment subject to medical approval.
- Life insurance amounts in excess of $50,000 may be taxable and may be included as taxable income on your W-2 form. See the Beyond Your Benefits section for further details.
- Free will preparation services are offered by Hyatt Legal Plans, a Metlife company. To utilize this service or for further assistance, contact Hyatt Legal Plans Toll Free at 1-800-821-6400, provide them with the Miami-Dade County Group Number 25800 and your social security number.
- An employee must be actively at work for coverage to begin. This also applies to increases in coverage.

How to Enroll for Group Term Optional Life Coverage

When eligible, you must complete a beneficiary designation form to enroll and indicate the level of coverage. If you don't enroll during your initial eligibility period, an Optional Life open enrollment is held once a year in early spring. You may submit an application, but it will be subject to medical approval. You must be actively at work for coverage to be effective.

Other benefits provided by Miami-Dade County

In addition to the group medical, dental and vision plans, Flexible Benefits Plan, Group Legal Services and your Flex Dollars, your benefits package also includes:

- Paid annual and sick leave
- 13 paid holidays
- Membership in either of the Florida Retirement System (FRS) plans
- Workers' Compensation
- Unemployment Compensation
- Social Security
- Employee Discount Program
- Tuition Refund and
- County Death Benefit.

COBRA Q&A

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans, including Healthcare Flexible Spending Accounts (Healthcare FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from your health plan or FBMC. COBRA information packets are sent by the insurance carriers to terminating employees within fourteen (14) days of notification of termination from County service. The County's notification to the plans is through a biweekly listing issued after the employee's department processes the termination through the payroll system. Group medical, dental, vision and basic\optional life insurance coverage (if enrolled) ceases the last day of the pay period in which the termination date falls and for which the employee experiences a regular insurance deduction or made direct payments to the Benefits Administration Unit (if on an unpaid leave of absence). If you exercise your rights under COBRA, upon receipt of your initial premium the insurance plan will reinstate your coverage retroactive to the group benefits termination date (without a gap). The HIPAA certificates will be issued by your medical insurance carrier, at the same time the COBRA notice is issued. For more information, please contact the insurance carrier. The employee or a family member has the responsibility of directly informing the health plan of a divorce, or a child losing dependent status. Requests must be made on a timely basis.

Basic\optional life insurance coverage is not subject to COBRA. If covered under the basic or optional life plan, the terminating employee will have the opportunity to convert to a private policy without being subject to evidence of insurability and will receive a conversion notice by mail. Employees may convert up to the volume of life insurance in force at the termination of employment, or convert amounts as determined by the Metropolitan Life Insurance Company. To obtain the life insurance conversion rates, contact the insurance carrier at the phone number listed on the conversion notice.

How long will continuation coverage last?

FSAs

If you fund your Healthcare FSA entirely, you may continue your Healthcare FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the Healthcare FSA for the year. For example, if you elected a maximum Healthcare FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Healthcare FSA for the remainder of the plan year or until such time that you receive the maximum Healthcare FSA benefit of $1,000. Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time.

If your employer funds all or any portion of your Healthcare FSA, you may be eligible to continue your Healthcare FSA beyond the plan year in which the qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special contribution rules for employer-funded Healthcare FSAs. If you have questions about your employer-funded Healthcare FSA, call FBMC at 1-800-342-8017.

Health Plans

You will be able to continue medical, dental and vision for up to 18 months if you lose group coverage due to termination of employment or reduction in hours. If your covered dependent(s) lost group coverage (for example, due to divorce, your death or child reaching the limiting age), coverage may be continued for up to 36 months from the qualifying event. See your Summary Plan Description (SPD) or certificate of coverage for other COBRA-qualifying events and explanation of your COBRA rights.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage the latter of 60 days from the date of COBRA notice or qualifying event. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. Additionally, payment must be received within **45 days** of COBRA election. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within **45 days** after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

COBRA Q&A

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay 102 percent of the cost of group health coverage. For Healthcare FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

When and how must payment for continuation of coverage be made?

First payment for continuation coverage

If you elect continuation of coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage **within 45 days after the date of your election.** (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that **45 days**, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact FBMC to confirm the correct amount of your first payment (for FSAs). Your health plan will notify you of the exact premium payable.

Instructions for sending your first payment for continuation coverage will be shown on your COBRA Election Notice/Form.

Periodic Payments for Continuation Coverage:

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the **first day of each month.** If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA Election Notice/Form.

Grace Periods for Periodic Payments:

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

For More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or certificate of coverage. You can get a copy of your summary plan description or certificate of coverage from FBMC (for FSAs) or your health plan.

Keep Your Address Updated

In order to protect your family's rights and to receive useful benefits information, you must keep your Departmental Personnel Representative informed of any change in your address. You should also keep a copy, for your records, of any notices you send to FBMC or your health plan.

DENTAL

2007 COBRA Monthly Rates

	Standard	Enriched
Met Life		
Single	$33.50	$43.85
2 Persons	$66.26	$86.70
Family	$106.79	$139.78
American Dental Plan		
Single	$8.80	$11.56
2 Persons	$14.54	$19.16
Family	$22.25	$30.45
Oral Health Services		
Single	$8.80	$11.56
2 Persons	$14.54	$19.16
Family	$22.25	$30.45

MEDICAL

2007 COBRA Monthly Rates

CIGNA Health Plan	
Single	$772.59
2 Persons	$1452.41
Family	$1717.06
AvMed Health Plan	
Single	$508.23
2 Persons	$868.97
Family	$997.55
Humana Health Plan	
Single	$567.31
2 Persons	$969.99
Family	$1111.81

JMH	
Single	$506.22
2 Persons	$864.88
Family	$992.86
Vista Healthplan	
Single	$459.55
2 Persons	$785.81
Family	$900.69

Optix Vision	
Single	$5.08
2 Persons	$10.17
Family	$18.74

Leave of Absence Q&A

What is the cost to maintain group benefits while on an approved Leave of Absence (LOA) without pay?

The premium you are responsible for depends on the type of leave. If your leave is illness related (i.e. Family Medical Leave (FMLA), disability, worker's compensation, maternity etc.), you will only be responsible for paying the bi-weekly insurance contributions that are usually withheld from your paycheck. If your leave is other than illness related (i.e. educational, suspension, personal, etc.), you will be responsible for paying both the biweekly employee and County contributions. Your Departmental Personnel Representative (DPR) should provide you with an LOA informational package, billing notice and remittance form. Contact your DPR for additional information.

When are Leave of Absence payments due?

Your DPR will provide you with a leave of absence package which explains what needs to be done to maintain your insurance while on leave, if you so choose. It also includes instructions on where payments must be sent. The first payment is due within two weeks of your last payroll deduction for benefits. Thereafter, premium payments are due bi-weekly in advance of the pay period to be covered. If coverage is cancelled due to non-payment of premiums when due, you will only be allowed to re-enroll during the next annual open enrollment period. Please follow-up with your DPR to receive this information when on an approved LOA.

If dependent premiums become a financial hardship, may I delete my dependent(s) from my health insurance while on an approved leave without pay status?

Yes. You may delete your dependent(s) while on an approved leave without pay by submitting a completed Flexible Benefits Change in Status Form and Insurance Status Change Form. You must submit these forms to your DPR within **45 days** of being in a no-pay status.

May I temporarily cancel my health insurance for the period while I am on a leave without pay status?

You may submit a completed Flexible Benefits Change in Status Form and Insurance Status Change form within **45 days** of being in a leave without pay status to temporarily cancel your health insurance coverage. Upon return to pay status (within **45 days**), you must re-submit a completed Flexible Benefits Change in Status form and Insurance Status Change Form to your DPR to reinstate coverage.

TERMS AND CONDITIONS

Taxable Benefits and the IRS

Disability Income Protection - Disability benefits may be taxed when an employee becomes disabled depending on how the premiums were paid during the year of the disabling event. For example, if you purchased disability coverage with pre-tax premiums and/or nontaxable employer credits, any disability payments received under the plan will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any disability payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis and a disability entitles you to receive payments, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax advisor for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

Life Insurance Premiums and the IRS

According to IRS regulations, you can pay premiums tax free on your first $50,000 of life insurance. You must pay tax on premiums for coverage exceeding $50,000. The first $50,000 limit includes any life insurance provided to employees by Miami-Dade County. Premiums for additional life insurance exceeding the IRS $50,000 maximum must be paid for with after-tax money.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided, not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s), and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies, and procedures from time to time adopted.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.
However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction.

FBMC Privacy Notice 4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal-and sometimes, sensitive-information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:
   - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
   - Responses from you and others such as information relating to your employment and insurance coverage.
   - Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
   - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

   Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.myFBMC.com. You have a right to a paper copy at any time. Contact FBMC Customer Service at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

PLEASE READ: This notice advises Flexible Spending Account participants of the identity and relationship between Miami-Dade County and its Contract Administrator, Fringe Benefits Management Company (FBMC). FBMC is not an insurance company. FBMC has been authorized by your employer to provide administrative services for the Flexible Reimbursement Account plans offered herein. FBMC will process claims for reimbursement promptly. In the event there are delays in claims processing, you will have no greater rights in interest or other remedies against FBMC than would otherwise be afforded to you by law.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

Important Notice of Prescription Coverage & Medicare

Important Notice About Your Prescription Drug Coverage and Medicare From Miami-Dade County To Active Employees & Dependents Participating in the Following County-Sponsored Health Plans

AvMed Health Plan HMO • CIGNA HealthCare POS • Humana, Inc. HMO
JMH Health Plan HMO • VISTA Healthplan, Inc. HMO

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Miami-Dade County and prescription drug coverage for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Miami-Dade County has determined that the prescription drug coverage offered by the above listed County plans, on average for all plan participants, is expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Miami-Dade County prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of you current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Miami-Dade County and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the following November to enroll.

For more information about your current prescription drug coverage, refer to your certificate of coverage issued by your medical insurance plan, or visit www.miamidade.gov/benefits

You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. More information about Medicare prescription drug plans is available from these places:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: May 16, 2006
Name of Entity: Miami-Dade County
Contact-Position/Office: GSA Risk Management, Benefits Administration Unit
Address: 111 NW 1st Street, Suite 2340
Phone Number: (305) 375-4288, (305) 375-5633

Health Benefits Notice of Privacy Practices

MIAMI-DADE COUNTY HEALTH BENEFITS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes how Miami-Dade County's (the "County's") medical and flexible spending account benefits programs, collectively referred to as the "Plans," may use and disclose Protected Health Information ("PHI" or "health information"). Protected Health Information is individually identifiable information about your past, present or future health or condition, health care services provided to you, or the payment for health services, whether that information is written, electronic or oral. This notice also describes your rights under federal law relating to that information. It does not address medical information relating to disability, workers' compensation or life insurance programs, or any other health information not created or received by the Plans.

HOW THE PLANS MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

For Treatment. While the Plans generally do not use or disclose your PHI for treatment, the Plans are permitted to do so if necessary. For example, the Plans may disclose PHI if your doctor asks for preauthorization for a medical procedure, the Plan may provide PHI about you to the company that provides preauthorization services to the Plan.

For Payment. The Plans may use and disclose your health information for payment of claims. Such purposes include, but are not limited to, eligibility, claims management, precertification or pre-authorization, medical review, utilization review, adjustment of payments, billing, and subrogation. For example, a detailed bill or an "Explanation of Benefits" may be sent to you or to the primary insured or "subscriber" by a third-party payor that may typically include information that identifies you, your diagnosis, and the procedures you received.

For Health Care Operations. The Plans may use and disclose health information about you regarding day-today Plan operations. Such purposes include, but are not limited to, business management and administration, business planning and development, cost management, customer service, enrollment, premium rating, care management, case management, audit functions, fraud and abuse detection, performance evaluation, professional training, provider credentialing, formulary development, and quality assurance or other quality initiatives. For example, the Plans may use or disclose information about your claims history for your referral for case management services, project future benefit costs, handle claims appeals or audit the accuracy of the claims processing performed by a third party payor.

To the Plan Sponsor. The Plans may disclose health information to the County, but the County has put protections in place to assure that the information will only be used for plan administration purposes, and never for employment purposes. For example, the County may become involved in resolving claim disputes or customer service issues.

As Required by Law. The Plan may use or disclose health information about you as required by state and federal law. For example, the Plan may disclose information for the following purposes:

- for judicial and administrative proceedings;
- to report information regarding victims of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in the performance of their law enforcement duties.

To Business Associates. There are some services the Plan provides through contracts with business associates. We may disclose your health information to our business associates so that they can perform the jobs we have asked them to do, for example, claims payment or appeals on behalf of the County by a third-party payor and claims audits by third-party firms to assure contract compliance. To protect the privacy of your health information, we contractually require business associates to appropriately safeguard that information.

For Health-Related Products and Services. The Plans may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities in the prevention or control of disease, injury, or disability, or for other activities relating to public health.

For Health Oversight. We may disclose your health information to a health oversight agency for activities authorized by law such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee benefit programs, other government regulatory programs and civil rights laws.

For Research. We may disclose your confidential information for research purposes, subject to strict legal restrictions.

To Personal Representatives and Some Relatives. We may use or disclose your information to a personal representative formally designated by you or designated by law or, under circumstances, to a close relative such as the subscriber primarily responsible for your coverage or the parent of a minor child.

For Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or another person pursuant to applicable law.

For Governmental Functions. Specialized governmental functions such as the protection of public officials or reporting to various branches of the armed services may require the use or disclosure of your health information.

For Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws and regulations relating to workers compensation or other similar programs established by law.

No Other Uses. Other uses and disclosures will be made only with your prior written authorization. You may revoke this authorization except to the extent a Plan has already made a disclosure in reliance on such authorization.

YOUR LEGAL RIGHTS

The federal privacy regulations give you the right to make certain requests regarding health information about you:

Right to Request Restrictions. You have the right to request that the Plan restrict its uses and disclosures of PHI in relation to treatment, payment, and health care operations. Any such request must be made in writing and must state the specific restriction requested and to whom that restriction would apply. The Plan is not required to agree to a restriction that you request.

Right to Request Confidential Communications. You have the right to request that communications involving your PHI be provided to you at a certain location or in a certain way. Any such request must be made in writing. The Plans will accommodate any reasonable request if the normal method of communication would place you in danger.

Right To Access Your Protected Health Information. You have the right to inspect and copy your PHI maintained in a "designated record set" by the Plan. The designated record set consists of records used in making payment, claims adjudication, medical management and other decisions. The Plan may ask that such requests be made in writing and may charge reasonable fees for producing and mailing the copies. The Plan may deny such requests in certain cases.

Right to Request Amendment. You have the right to request that your PHI created by the Plan and maintained in a designated record set be amended, if that information is in error. Any such request must be made in writing and must include the reason for the request. If the Plan denies your request for amendment, you may file a written statement of disagreement. The Plan has the right to issue a rebuttal to your statement, in which case, a copy will be provided to you.

Right to Receive An Accounting of Disclosures. You have the right to receive an accounting of all disclosures of your PHI that the Plan has made, if any. This accounting does not include disclosures for payment, health care operations or certain other purposes, or disclosures to you or with your authorization. Any such request must be made in writing and must include a time period, not to exceed six (6) years. The Plan is only required to provide an accounting of disclosures made on or after April 14, 2003. If you request an accounting more than once in a 12-month period, the Plan may charge you a reasonable fee.

All requests listed above should be submitted in writing to the County's Chief Privacy Officer (see Contact Information below).

THE PLANS' OBLIGATIONS

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

THIS NOTICE IS SUBJECT TO CHANGE

We may change the terms of this Notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future. Revised Notices will be made available to you in writing as required.

COMPLAINTS

You have a right to file a complaint if you believe your privacy rights have been violated. You may file a complaint by writing to the County's Chief Privacy Officer, General Services Administration, 111 NW 1 Street, Suite 2340, Miami, FL 33128. You may also file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

2007 Benefits Handbook

www.miamidade.gov/OpenEnrollment

www.miamidade.gov/benefits